STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a Federal Complaint Survey. The survey was extended survey on 10/09/15. Complaint # IN00164290 - Substantiated with deficiencies Survey dates: October 8, 9, and 13, 2015 Facility Number: 013568 Medicaid Provider ID: Not Available Census: 6 Home visits: 1 Active Clinical records reviewed: 6 Closed records reviewed: 3 All Ages Home Health Care, Inc. is precluded from providing its own training and competency evaluation program for a period of 2 years beginning October 13, 2015, to October 13, 2017, for being found out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services, and Administration, 484.18 Acceptance of Patients, Plan of Care, Medical Supervision, 484.30 Skilled Nursing Services, 484.36 Home Health Aide Services, 484.48 Clinical Records, and 484.55 Comprehensive Assessment of Patients.	G 000		
G 114	484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally	G 114		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 114	Continued From page 1 funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. This STANDARD is not met as evidenced by: Based on record review the agency failed to inform the patient, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for in 9 of 9 records reviewed, potentially affecting all 6 patients receiving services within the agency. (#1, 2 - 9) Findings include: 1. Clinical record number 1, SOC (start of care) 07/20/15. The Admission Service Agreement dated 07/20/15, was reviewed and failed to evidence the charges that may occur for services not covered by the insurance benefit. 2. Clinical record number 2, SOC 07/29/15. The Admission Service Agreement dated 04/28/15, was reviewed and failed to evidence the charges that may occur for services not covered by the insurance benefit. 3. Clinical record # 3, SOC (start of care) 11/13/14. A letter to the patient dated 06/08/15, indicated " ... As it was explained during the admission process, we agreed to provide care for you at no charge until our temporary license was transitioned to a full licensure .... We are offering you and / or your family a five (5) weekday decision period starting from the date you receive this letter to make your decision on	G 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 114	Continued From page 2	G 114		

this process. At the end of that five (5) day period, if we have not heard from you, we will contact ou to clarify your decision "

a. The Home Health Advance Beneficiary Notice dated 11/13/14, indicated "private services to be provided at no charge."

b. A letter to the patient dated 11/13/14, indicated "Your services will be provided under the following payor source ... Other: no charges .... "

c. The Admission Service Agreement dated 11/13/14, failed to include that the admission was part of the provisional licensure and the charges that may occur for services once the agency passed their provisional survey / received their licensure.

d. The letter to the patient / family failed to include charges that may be imposed should services continue.

4. Clinical record number 4, SOC 08/04/15. The Admission Service Agreement dated 08/04/15, was reviewed and failed to evidence the charges that may occur for services not covered by the insurance benefit.

5. Clinical record number 5, SOC 07/31/15. The Admission Service Agreement dated 06/02/15, was reviewed and failed to evidence the charges that may occur for services not covered by the insurance benefit.

6. Clinical record number 6, SOC 08/05/15. The Admission Service Agreement dated 10/28/14, was reviewed and failed to evidence the charges

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 114	Continued From page 3	G 114		

that may occur for services not covered by the insurance benefit.

7. Clinical record number 7, SOC 08/05/15. The Admission Service Agreement dated 02/04/15, was reviewed and failed to evidence the charges that may occur for services not covered by the insurance benefit.

8. Clinical record number 8, SOC 09/08/15. The Admission Service Agreement dated 10/30/14, was reviewed and failed to evidence the charges that may occur for services not covered by the insurance benefit.

9. Clinical record number 9, SOC 09/30/15. The Admission Service Agreement dated 04/03/14, was reviewed and failed to evidence the charges that may occur for services not covered by the insurance benefit.

10. An undated policy titled "Service Agreement" indicated, "A Service Agreement shall be developed with all clients upon admission, before care is provided. The service agreement will identify the services to be provided, disciplines providing care, charges and exprected sources of reimbursement for services. The client will be informed of their liability for payment ... 2. Before care is provided, the client shall be advised of ... c. The fees for services. d. The extent to which payment for services may be expected from ... Medicaid or any other third party paer known to the agency ... f. The charges the individual may have to pay. g. Any limitations on service and admission and discharge criteria ... 4. The client shall be advised, of any changes intype of frequency of services, coverage of services and any change in financial liability. Changes in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 114	Continued From page 4 financial liability will be verbal and in writing as soon as possible, but no later than, 30 calendar days from the date the agency becomes aware of a a change .... "	G 114		
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure. This STANDARD is not met as evidenced by: Based on record review, the agency failed to update their policy to reflect per 410 Indiana Administrative Code 17-2-1-(d) for 1 of 1 agency. Finding included: 1. An undated job description titled "Director of Nursing" indicated, " ... Qualifications ... Minimum one [1] year clinical experience .... " 2. The 410 Indiana Administrative Code 17-2-1-(d) indicated, "A physician or a registered nurse who has two (2) years of nursing experience, with at least one (1) year of supervisory or administrative experience, shall supervise and direct nursing and other therapeutic services." The agency failed to update their policy to reflect that the Director of Nursing must have at least two years clinical experience.	G 118		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD	G 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 5 The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 1 of 1 home visit observation. (#4) Findings include: 1. An undated policy titled "Infection Prevention / Control" indicated, " ... Standard Precautions - Tier One ... 2. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client, and when indicated to prevent transfer of microorganisms between other clients or the environment ... 6. Equipment used for client care is properly cleaned and reprocessed. Single - use items are discarded .... " 2. An undated policy title "OSHA Infection Control / Exposure Control Plan" indicated, "Agency shall maintain policies and procedures for the care of clients with infectious and / or contagious diseases and for infection control practices by employees; these policies and procedures shall conform with OSHA regulations, Accreditation standards, local and state laws, and currently accepted standards of practice .. Special Instructions 1. Client infection control procedures shall include, but not be limited to: a. Wearing	G 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 6	G 121		

and changing gloves as necessary during the delivery of client care. b. Appropriate wound and skin care and dressing techniques following sterile or aseptic dressing procedures. c. Appropriate handling and disposal of waste products ... f. Frequent hand washing by home health care employees: Before and after the provision of direct client care ... After handling soiled or contaminated materials ... after removing gloves ... Environmental infection control procedures include, but are not limited to ... h. keeping the client's environment clean, neat, and orderly. This includes keeping supplies off the floor and out of reach of children .... "

3. The Centers for Disease Control Standard Precautions indicated, "IV. Standard Precautions ... IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces ... Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves ... IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 7	G 121		

that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently ... IV.B. Personal protective equipment (PPE) ... IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin ... could occur. "

4. A home visit was made to patient #4 with the Director of Nursing on 10/09/15 at 10:30 AM. The Director of Nursing was observed providing wound care to the patient's right and left trochanter, two areas on the left buttocks, and left heel. The Director of Nursing was observed to go to her nursing bag and remove a pair of gloves and placed them on the patient's bedside table. The Director of Nursing then began to go through the patient's boxes of dressing supplies and returned to the patient, put on the gloves and began treatment without washing / sanitizing her hands. During the first dressing change, the Director of Nursing realized she didn't have her scissors and removed her gloves and got into her nursing bag to retrieve the scissors without washing / sanitizing her hands. The Director of Nursing then walked back to the patient and reapplied gloves without washing / sanitizing her hands. After using a Q-tip to tuck the kerlix in the right trochanter wound, the Director of Nursing placed the Q-tip with the remaining kerlix and reused the same Q-tip while tucking the kerlix to the left trochanter wound. The Director of Nursing failed to dispose the used Q-tip and used a new Q-tip for the left trochanter wound. Once the Director of Nursing got to the left heel, the Director of Nursing removed her gloves, used hand sanitizer, then proceeded to wipe her hands

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 8 on her jeans, failing to allow her hands to dry by air. The Director of Nursing went back to the boxes of dressing supplies, returned to the patient and reapplied gloves without washing / sanitizing her hands. Upon completion of the dressing change to the left heel, the Director of Nursing removed her gloves, used hand sanitizer, and proceeded to wipe her hands on her jeans again, failing to allow her hands to dry by air. After the Director of Nursing completed her assessment, the Director of Nursing left the patient's home, leaving the soiled dressings in a bag on the patient's floor, opened. The patient was interviewed during this time and stated that his / her routine nurse takes the soiled bag out and disposes it for him / her. 5. On 10/09/15 at 09:30 AM, the Director of Nurisng stated that she may not be proficient with dressings changes but she felt that she generally did a good job.	G 121		
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure the Organizational Chart included the name of the employees under the title / position from the President down to the patient for 1 of 1 agency (See G 123); failed to ensure that a quality assessment and performance improvement program was implemented since the provisional licensure survey, failed to ensure that second step PPD,	G 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 122	Continued From page 9 criminal background checks, and verification of a home health aide registery for 3 of 5 personnel records reviewed, failed to ensure visits were made, wound treatment and management was followed in accordance to the plan of care for 4 of 9 records reviewed, failed to ensure wound treatments were administered by the skilled nurse as ordered by the physician for 2 of 2 records reviewed on patients with wounds, failed to be prepared and knowledgeable in providing wound treatment and assessment for 1 of 1 home visits observed and failed to completely assess and document a patient's wound for 2 of 3 records reviewed of patients with wound treatments (See G 133); and failed to ensure that a qualified person was put into place for the Director of Nursing position and failed to ensure that whomever was put into place was properly trained and competent to assist the staff with patient care and the day to day operations of the office that is required by Centers for Medicare and Medicaid (See G 134). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.14 Organization, Services, and Administration.	G 122		
G 123	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable.	G 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 123	Continued From page 10 This STANDARD is not met as evidenced by: Based on record review, the Administrator failed to ensure the Organizational Chart included the name of the employees under the title / position from the President down to the patient for 1 of 1 agency. Finding included: 1. On 10/08/15, the organizational chart was provided by the Administrator. The organizational chart provided indicated titles / positions but failed to include the name of employee under the title / position.	G 123		
G 133	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on record review, interview and observation the agency failed to ensure the administrator organized and implemented a quality assessment and performance improvement program since the initial licensure survey; a system to ensure personnel records were complete to include second step PPD's,	G 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 11	G 133		

criminal background checks, and verification of a home health aide registry in 3 of 5 personnel records reviewed (director of nursing, employee C and E); a system to ensure clincal visits were completed, wound treatment and managment was followed in accordance to the plan of care for 5 of 9 patients sampled (Patient #1, 2, 3, 5, 7); a system to ensure 1 of 1 staff registered nurse observed (director of nursing) during 1 of 1 home visit of a patient with wounds (patient #4) was knowedgeable and competent in providing wound treatment and assessment; and a system to ensure nursing was competent in assessment and documentation of wounds in 2 of 4 patients sampled with wounds (patient #4 and #9).

Findings include:

A.1.The agency had an initial licensure survey dated April 20, 21, 22, and May 4, 2015. The agency had to put a plan of correction in place by May 20, 2015. The corrections included, but not limited to:

a. Weekly monitoring of patient's plan of care visits and verification of these visits for documentation of missed visits and notification of the patient's physician.

b. Staff in-services on the need to document nutritional requirements on the plan of care.

c. The professional staff was to be in-serviced on the requirement to document with a physician's order for the specific wound care ordered and any changes in wound care per physicians order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 12	G 133		

d. The Director of Nursing will be responsible for reviewing patient care plans and physician's orders on a weekly basis and securing physician's order for care changes as needed on each patient to prevent recurrence of this deficiency.

e. The Director of Nursing was responsible for monitoring patient care and conferencing with other professional staff to determine specific patient needs and instituting the appropriate changes in regard to the home health aide care plan.

f. The professional staff was in-serviced on the requirement of detailed documentation and correctness in regards to medication profile. The Director of Nursing will be responsible for reviewing all patient admissions, resumption of care, re-evaluations and 60 day certifications to prevent recurrence of this deficiency.

There was no document to review to support theagency failed to develop, implement, maintain, and evaluate a quality assessment and performance improvement program.

2. An interview with the Director of Nursing on 10/09/15 at 11:45 AM, stated that she is in the field often and does not spend a large amount of time in the office. The Director of Nursing indicated she started working for the company on June 1, 2015 and that the former Director of Nursing stepped down to be a per diem nurse in the field.

3. An interview with the Administrator on 10/09/15 at 1:50 PM, stated that the Director of Nursing did all the admissions, recertifications,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 13	G 133		

and resumption of care visits.

4. An interview with the Administrator on 10/13/15 at 2:45 PM, stated that the Director of Nursing is responsible for the chart audits but was not able to produce any audited material. The administrator also stated the agency has not had a QAPI meeting to review audit findings since the initial licensure survey.

B1. The Director of Nursing's, date of hire 06/10/15, personnel record was reviewed and indicated the agency provided a PPD upon hire. The personnel record failed to evidence a PPD had been done within 12 months of the Director of Nursing date of hire. The agency failed to provide a second step PPD.

2. Employee C's, a home health aide, date of hire 07/28/15, personnel record was reviewed and failed to include a criminal background check.

3. Employee E's, a home health aide, date of hire 09/08/15, personnel record was reviewed and failed to include verification of the home health aide registry.

4. The Administrator was unable to provide additional documentation by the exit conference on 10/13/15 at 3:50 PM, for the required items missing in the personnel records of the director of nursing, employee C and employee E.

C1. Clinical record of patient#1, SOC (start of care) 07/20/15, was reviewed and included a plan of care established by a physician for certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 14	G 133		

and home health aide three hours in the morning and two hours in the evening, 7 days a week. Patient diagnoses included but were not limited to: cerebral vascular accident [stroke] with hemiplegia, depression, lymphadema, stasis ulcers, and diabetes. Treatment orders indicated to apply non-adherent dressing and secure with kerlix or similar product and to teach husband to reapply and evaluate wound progress weekly.

a. Review of the skilled nursing notes indicated there were no skilled nursing visits between 07/20/15 to 08/03/15, the skilled nurse made one extra visit during week one, two extra visits during week two, and no skilled nursing visits during week four, five, and six. The skilled nurse failed to follow the plan of care.

1. Skilled nursing visit note dated 08/05/15, indicated the nurse was waiting a call back from the physician and that a treatment plan was being developed. The visit note failed to include treatment provided during the visit and that the spouse was educated on management of the wound.

2. Skilled nursing visit note dated 08/12/15, indicated the nurse dressed the wound with a waterproof non-adhesive edge gauze. The skilled nurse failed to follow the current treatment order and failed to indicate if the spouse was educated on the management of the wound.

3. Skilled nursing visit note dated 08/13/15, failed to indicate if kerlix was applied to the wound after applying telfa (non adhering dressing) and failed to indicate if the spouse was educated on the management of the wound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 15	G 133		

4. Skilled nursing visit note dated 08/14/15, failed to indicate if the spouse was educated on the management of the wound.

b. Review of the Home Health aide visit notes indicated there were no home health aide visits between 07/20/15 to 08/03/15, AM visit were missed on 08/05, 08/07, 08/14, 08/15, 08/16, 08/17, 08/19, 08/23, 08/30, 09/03, 09/07, 09/08, 09/09, 09/10, and 09/11/15. PM visits were missed on 08/06, 08/10,08/15, 08/16, 08/17, 08/22 (only 1 hour provided), 08/24, 08/25, 08/26, 08/27, 08/31, 09/01, 09/02, 09/03, 09/07, 09/08, 09/09, 09/10, and 09/11/15. Visit hours that were combined in one visit on 08/04 (9:30 AM - 2:30 PM), 08/08 (9:00 AM - 1:00 PM), 08/18 (10:30 AM - 2:30 PM), 08/19 (1:00 - 5:15 PM), and 08/20 (9:00 AM - 1:15 PM).

2. Clinical record of patient #3, SOC 11/13/14, was reviewed and included a plan of care established by a physician for certification period of 05/14/15 to 07/13/15, with orders for skilled nursing one time a week for 9 weeks for medication set up, homemaker one hour per week for nine weeks.

a. Review of the skilled nursing notes indicated the skilled nurse failed to make a nursing visit during week one.

b. Review of the home maker visit notes indicated the home maker failed to make a visit during week one.

3. Clinical record of patient #5, SOC 07/31/15, was reviewed and included a plan of care established by a physician for certification period of 07/31/15 to to 09/10/15, with orders for skilled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 16	G 133		

nursing two to three times a month for two month to assess, medication compliance, safety, home health aide supervision, assess patient's overall health and home health aide services three to four hours a day, three to five days a week to assist with personal care to include partial to complete bath or shower, shampoo, skin care, meal preparation, light housekeeping to help maintain clean and safe environment.

a. Review of the skilled nursing notes were reviewed and failed to evidence skilled nursing visits between 07/31/15 to 09/18/15.

b. The clinical record was reviewed on 10/13/15 at 12:00 PM. A physician order dated 09/03/15, indicated "HHA [home health aide] visits three to five hours per day, three to five days per week. PT [Physical therapy] to restore function based on the following clinical findings, balance problems with household transfers, require therapy. Weakness limiting ability to stand without assist. Require strength training. PT to develop program home health aide can follow .... " Review of the home health aide visit notes on 10/13/15 at 12:00 PM, indicated there were no home health aide visits between 07/31/15 to 09/06/15.

a. The record indicated physical therapy had not conducted an assessment of the patient in accordance with the plan of care, nor had developed a program for the home health aide since the order was received on 9/3/15.

b. A physician order dated 09/17/15, indicated to "decrease home health aide visits to one hour per day, secondary to Medicaid approval. Increase visits to seven days per week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 17	G 133		

secondary to family weekend coverage not available at this time." Review of the home health aid visits notes, indicated that the home health aid started seeing the patient for one hour per day on 09/13/15. The home health aide failed to follow the plan of care.

c. An interview with the Administrator on 10/13/15 at 12:20 PM, stated that the patient did not start services until after the medicaid prior authorization was approved.

C4. Clinical record #7, SOC 08/05/15, included a plan of care established by a physician for certification period of 08/05/15 to to 09/30/15, with orders for skilled nursing one to four times monthly for medication set up and assessment. Review of the skilled nursing notes, failed to evidence skilled nursing visits 08/05/15 to 09/10/15.

C5. Clinical record #9, SOC 09/30/15, included a plan of care established by a physician for certification period of 09/30/15 to 11/26/15, with orders for skilled nursing one time a week for nine weeks and home health aide services three to four hours a day, three to five days a week for nine weeks.

a. Review of the skilled nursing visit notes indicated that the skilled nurse made an extra visit during week one. The skilled nurse failed to follow the plan of care.

b. Review of the home health aide visit notes indicated that the home health aide did not start services until week two on 10/06/15. The home health aide failed to follow the plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 18	G 133		

C6. The Administrator was unable to provide any further documentation and / or information regarding the findings referenced above by the exit conference on 10/13/15 at 3:50 PM.

D1. Clinical record #1, SOC (start of care) 07/20/15, include a plan of care established by a physician for certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care. Patient diagnoses included cerebral vascular accident [stroke] with hemiplegia, depression, lymphadema, stasis ulcers, and diabetes. Treatment orders indicated to apply non-adherent dressing and secure with kerlix or similar product.

a. Skilled nursing visit note dated 08/12/15, indicated the nurse dressed the wound with a waterproof non-adhesive edge gauze. The skilled nurse failed to follow the current treatment order.

b. Skilled nursing visit note dated 08/13/15, indicated the nurse changed a Band-Aid to a wound to the 2nd toe on the left foot that was identified on 08/05/15. The skilled nurse failed to obtain an order for treatment of the 2nd toe wound on the left foot.

D2. Clinical record #4, SOC 08/04/15, included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15 with orders for skilled nursing daily for wet to dry dressing changes to "decubes both hips."

a. During a home visit on 10/09/15 at 10:30 AM, the Director of Nursing was observed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 19	G 133		

perform a dressing change to an area between the left trochanter and buttock, as well as the right and left trochanter, left buttock, The Director of Nursing was observed to clean the wounds with q-tips and wound cleanser, wiped the wounds with 4 x 4 gauze, sprayed wound cleanser two to three times to an antimicrobial kerlix vs the traditional kerlix, as instructed by the patient, and firmly packed the right / left trochanter and left buttocks wound, applied the same kerlix to the wound between the left buttocks and trochanter, covered all wounds with ABD pads, and secured the dressings with hydrofilm. The Director of Nursing was also observed to clean the left heal with wound cleanser, applied a dry dressing and secured with cover roll. During the observation, the Director of Nursing confirmed with the patient of the treatments being done by Employee H, a Registered Nurse, who routinely sees the patient. The patient had a large box of antimicrobial kerlix in his bedroom.

b. The clinical record was reviewed on 10/09/15 at 1:30 PM. The skilled nursing visit note dated 10/03/15, indicated Employee H observed the patient to have a new wound between the left buttocks and left trochanter. The description provided indicated the wound had slough but no drainage. A skilled nursing notes dated 10/04, 10/05, 10/06, 10/07, and 10/08/15, indicated Employee H provided wound treatment by cleansing the wound with wound cleanser, then applying normal saline wet to dry dressing and secured with cover-roll.

c. Skilled nursing visit notes from 08/06/15 to 08/29/15, 09/03/15 to 09/18/15, and 09/26/15 to 10/09/15, indicated the right / left trochanter and left buttock wounds were being cleaned with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 20	G 133		

wound cleanser, wounds being pack with normal saline wet kerlix, then 4 x 4, ABD padding, and secured with hydrofilm transparent dressing. The left heel was being cleansed with wound cleanser, 4 x 4 normal saline wet to dry, and coverall to secure.

The Director of Nursing and Employee H was providing specific wound treatments, such as wound cleanser, antimicrobial kerlix, ABD, and hydrofilm to the right / left trochanter and left buttocks without a physician's order. The Director of Nursing and Employee H was providing wound treatments to the new pressure area between the left trochanter and buttock as well as the left heel without a physician's order.

D3. The Administrator was unable to provide any further documentation and / or information regarding the findings referenced above by the exit conference on 10/13/15 at 3:50 PM.

D4. An undated policy titled "Physician Orders" indicated, "All medications, treatments and services provided to clients must be ordered by a physician.

E1. Article 2. Standards for the Competent Practice of Rule 2. Registered Nursing. 848 IAC (Indiana Administrative Code) 2 - 2 -1 Responsible to apply the nursing process. Sec. 1. The registered nurse shall do the following: (1) Assess the patient / client in a systematic, organized manner ... (4) Implement strategies to provide for patient / client participation in health promotion, maintenance, and restoration. (5) Initiate nursing actions to assist the patient / client to maximize his or her health capabilities ... (7) Seek educational resources and create learning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 21	G 133		

experiences to enhance and maintain current knowledge and skills for his or her continuing competence in nursing practice and individual professional growth. 848 IAC 2 - 2 - 2 Responsibility as a member of the nursing profession. Sec. 1. The registered nurse shall do the following: (1) Function within the legal boundaries of nursing practice based on the knowledge of statutes and rules governing nursing. (2) Accept responsibility for individual nursing actions and continued competence. (3) Communicate, collaborate, and function with other members of the health team to provide safe and effective care. (4) Seek education and supervision as necessary when implementing nursing practice techniques ... 848 IAC 2 - 2 - 3 Unprofessional conduct Sec. 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (1) Using unsafe judgment, technical skills, or inappropriate behaviors in providing nursing care. (2) Performing any nursing technique or procedure for which the nurse is unprepared by education or experience .... "

E2. Clinical record #4, SOC 08/04/15, included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15 with orders for skilled nursing daily for wet to dry dressing changes to "decubes both hips."

a. During a home visit on 10/09/15 at 10:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 22	G 133		

AM, with the Director of Nursing, the patient was observed to have a wound to the right and left trochanter, left buttock, an area between the left trochanter and left buttock, and left heel. The Director of Nursing proceeded to ask the patient on the type of dressing to be used. The patient had instructed the Director of Nursing to use an AMD Anatomic kerlix roll and directed the Director of Nursing of the location of the dressing. After obtaining the special kerlix roll, the Director of Nursing proceeded to move items around on the bedside table and asked the patient where was the measuring tool so that she may measure his wounds and proceeded to tell the patient that he / she would have to talk her through the dressing. The patient right and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 gauze, took wound cleanser and sprayed over the Q-tip, and proceeded to clean the wound with the Q-tip and then wiped the wound bed with the 4 x 4 gauze. The Director of Nursing then proceeded to take the Q-tip and hovered over the wound then placed the Q-tip over top of the measuring tool on the 4 x 4 package, then placed the Q-tip in the package with the kerlix dressing. The patient was observed to have undermining and tunneled areas in all three wounds and the Director of Nursing failed to measure the undermining and tunneled areas.

The Director of Nursing then proceeded to ask the patient if the kerlix needed to be moistened. The patient informed the nurse yes and told the Director of Nursing that Employee H, the routine Registered Nurse / Case Manager, used Normal Saline to moistened the gauze. The Director of Nursing picked up a bottle that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 23	G 133		

labeled "Derma Gran Wound Cleanser" and informed surveyor that the bottle was Normal Saline. The Director of Nursing then squirted the kerlix gauze three times with the wound cleanser and proceeded to pack the right wound firmly with the kerlix, using the Q-tip that was used for cleaning. After packing the right wound, the Director of Nursing asked the patient if the ABD padding came next but the patient instructed the Director of Nursing that the 4 x 4 gauze came next, and proceeded to tell her how much 4 x 4 gauze to place over the kerlix packing. The Director of Nursing then placed the ABD and then the patient had to instruct the Director of Nursing on placement of the hydrofilm covering. The Director of Nursing proceeds to follow this same procedure and fashion to the left sided wounds, packing them firmly, and asking for direction and guidance from the patient. During the packing of the wound, the patient made facial expressions of discomfort. The patient had to inform the Director of Nursing of the new wound located between the left trochanter and buttocks. The Director of Nursing stated she had not noticed the wound and thanked the patient for pointing the wound out. Moving to the left heel, the Director of Nursing asked the patient what the treatment was that Employee H does to the area. The Director of Nursing proceeds to to ask the patient if Employee H wets the gauze and asked the patient the direction for which to place the gauze. Throughout the dressing change, the Director of Nursing continued to comment on her lack of abilities to perform the dressing change correctly and if she had seen the patient more often, she would be more proficient. The Director of Nursing failed to be prepared, demonstrate and verbalize competence of wound care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 24	G 133		

After the wound treatments, the Director of Nursing asked the patient what color was the drainage on the dressings that he / she had removed prior to our arrival. The Director of Nursing failed to educate the patient not to remove the dressings or to save the dressings in a bag so that the registered nurse may observe the dressings for signs of odor and infection.

b. The clinical record of patient #4's was reviewed on 10/09/15 at 1:15 PM. The Director of Nursing wound assessment on the start of care comprehensive assessment dated 08/04/15, indicated the right "hip" wound measured 7 x 5 x 2 cm (centimeters), left hip wounds 5 x 4 x 2 cm and 4 x 4 cm. The left heal failed to be measured.

c. A skilled nursing visit was made on 08/13/15, by Employee H. Two of the four wounds was measured. The right hip measured 18 x 8 x 3 cm and one of the left hip wounds 5 x 6 x 3 cm. The second hip wound and left heal failed to be measured. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

d. A skilled nursing visit was made on 08/14/15, by Employee H. The right hip measured 18 x 10 x 2 cm, the left hips measured 3 x 4 x 2 and 5 x 4 x 2 cm. The left heel measured 2 x 2 x 0.3 cm. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

e. A skilled nursing visit was made on 08/18/15, by Employee H. The right hip measured 18 x 15 x 3 cm, the left hips measured 3.5 x 3 x 1 cm and 5.1 x 4.0 cm. The left heel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 25	G 133		

measured 1 x 1 x 0.1 cm. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

f. A skilled nursing visit was made on 08/24/15, by Employee H. The right hip measured 17 x 15 x 3 cm, the left hips measured 3 x 3 x 2.1 cm, 4 x 4 x 3.5 cm. The left heel measured 1.5 x 1 x 2.1 cm. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

g. The patient was hospitalized from 08/30/15 to 09/02/15. A resumption of care comprehensive assessment dated 09/04/15, was performed by the Director of Nursing. The documented wound assessment provided the exact same description and measurements as the start of care comprehensive assessment dated 08/04/15.

h. An note in the patient's chart dated 09/04/15, was entered by the Administrator. The entry indicated that Employee H had "called to report that patients heel decube had reopened and was resuming the wet to dry dressings to left heel as ordered."

i. Review of the skilled nursing visit notes dated 09/05/15 to 09/14/15, the left heel was not included / documented in the daily wound wound treatments.

j. A skilled nursing visit was made on 09/07/15, by Employee H. The right hip measured 17 x 15 x 2 cm, the left hips measured 4 x 4.1 x 2 cm and 5 x 4.5 x 3.9 cm. The left heal wound failed to be measured.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 26	G 133		

k. A skilled nursing visit was made on 09/18/15, by Employee H. The right hip measured 18 x 14 x 3 cm, the left hips measured 15 x 14 x 2 cm and 8 x 9 x 3 cm. The left heal wound failed to be measured. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

l. The patient was hospitalized from 09/19/15 to 09/25/15. The clinical record failed to include a comprehensive assessment upon return from the hospital to include wound measurements and description.

m. A skilled nursing visit was made on 10/3/15, by Employee H. Employee H indicated the patient had a "decube open lt [light slough], no drainage and failed to provide measurements of the new wound, appearance of surrounding tissue. Skilled nursing visits from 09/26/15 to 10/02/15, failed to indicate that the patient was developing a pressure ulcer prior to eruption of skin on 10/03/15.

n. A skilled nursing visit was made on 10/04/15, by Employee H. The right hip measured 12 x 10 x 3 cm, the left hips measured 10 x 10 x 2 cm and 7 x 4 x 2 cm. The new area between the left "hips" measured 2.5 x 2.5 x 2 cm. The left heel measured 1 x 1 x 0.1 cm.

o. A skilled nursing visit was made on 10/09/15, by the Director of Nursing. The right hip measured 6 x 4 x 3 cm, the left hips measured 6 x 5 x 3 cm and 4 x 2 x 3 cm. The wound between the two left "hips" measured 3 x 2 x 0.5 cm, and the left heel measured 2 x 2 cm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 27	G 133		

The Director of Nursing failed to be accurate in her measures, label the left hips and heel wound correctly, as per previous measurement performed by Employee H.

Skilled nursing visit notes dated 08/06/15 to 08/29/15, 09/04/15 to 09/18/15, and 09/26/15 to 10/08/15, Employee H, indicated that the wounds were light pink with white - yellow slough tissue or partial granulation. Employee H failed to be document specific descriptions for each wound that provides location and percentage of pink to white tissue and slough, as well as the appearance of surrounding skin around each wound.

E3. Clinical record #9, SOC 09/30/15, included a plan of care established by the physician for the certification period of 09/30/15 to 11/26/15, with orders for skilled nursing one time a week for nine weeks to evaluate left below the knee stump for healing and possible skin breakdown and evaluate ulcer on right "bk" [below the knee] for progression to healing or non healing and increase size.

a. Review of the OASIS start of care comprehensive assessment dated 09/30/15, M1330 under the Integumentary Status, indicated the patient had a stasis ulcer that was unobservable and M1340 indicated the patient had an observable surgical wound that was fully granulating. The comprehensive assessment failed to include location, size, and description of the surgical incision and failed to include location of the stasis ulcer and reason for the ulcer to be unobservable.

b. Review of the skilled nursing notes dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 28 10/02/15, indicated the patient had an open wound to the right toe but failed to include an assessment of the surgical wound that was indicated in the comprehensive assessment. E4. The Director of Nursing was interviewed on 10/09/15 at 11:45 AM. The Director of Nursing stated that she had not worked as a nurse since November, 2014 and she had been an infusion nurse for many years. E5. The Administrator was interviewed on 10/09/15 at 1:30 PM. The Administrator stated Employee G, the former Director of Nursing, had stepped down to be a case manager in the field on an as needed basis and she was not sure if Employee G or Employee H, a Registered Nurse, had performed the skills check off with the current Director of Nursing. E6. The Director of Nursing personnel record was reviewed on 10/13/15 at 3:00 PM. The Director of Nursing indicated in her proficiency of wound care, that it had been more than 12 months since she had provided wound care. The personnel record failed to include a skills check off for wound care care by the agency after the Director of Nursing was hired. E7. An undated policy titled "Skilled Nursing Services", indicated "The registered nurse ... Provides services requiring specialized nursing skill .... "	G 133		
G 134	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs	G 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 29	G 134		

qualified personnel and ensures adequate staff education and evaluations.

This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the Administrator failed to ensure that a qualified person was put into place for the Director of Nursing position and failed to ensure that whoever was put into place was properly trained and competent to assist the staff with patient care and the day to day operations of the office that is required by Centers for Medicare and Medicaid.

Finding include:

1. The clinical record of patient #1, SOC 07/20/15, was reviewed on 10/08/15 at 2:30 PM. The clinical record included a plan of care established by a physician for a start of care date of 08/03/15 with a certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care. The treatment ordered on the plan of care indicated for the skilled nurse to apply non-adherent dressing and secure with kerlix or similar product.

a. Review of the service agreement indicated the patient had signed consents for treatment on 07/20/15. The Director of Nursing failed to update the plan of care to reflect the correct start of care date of 07/20/15 and a certification period of 07/20/15 to 09/17/15. The Director of Nursing failed to include the location of the patient's wound, how to clean the wound, and frequency of dressing changes on the plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 30 b. An OASIS start of care comprehensive assessment dated 08/03/15, indicated "M2250 Plan of Care Synopsis ... Does the physician - ordered plan of care include the following ... b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient / caregiver education on proper foot care - yes, c. Falls prevention interventions - yes, d. Depression interventions such as medication, referral for other treatment, or a monitoring plan or current treatment and / or physician notified that patient screened positive for depression - yes, e. Interventions to monitor and mitigate pain - yes, f. Interventions to prevent pressure ulcers - yes .... " The Director of Nursing failed to update the plan of care to include interventions listed b - f. c. An OASIS start of care comprehensive assessment dated 08/03/15 failed to include location and size of venous stasis ulcers. Failed to complete vital signs, cardiopulmonary assessments, complete the nutritional status, assessment of bowel elimination, abdomen assessment, neuro / emotional / behavioral status assessments, failed to address the depression screening score of 6 with the physician, failed to indicate if the patient was receiving psychiatric nursing services, failed to indicate if there was any management of equipment, failed to include 24 hr supervision / clear pathways / lock w/c with transfers / infection control measures under safety measures, and failed to indicate if instructions / materials were provided. Page 18 of the assessment failed to include skilled care provided during the admission visit. The Director of Nursing failed to complete the comprehensive assessment in its entirety and within 5 days of admission.	G 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 31	G 134		

d. The medication portion of the plan of care indicated "see attached medication profile." The Director of Nursing failed to include medications listed on the medication profile that the patient was taking / prescribed on the plan of care.

2. The clinical record of patient #2, SOC 07/29/15, was reviewed on 10/08/15 at 3:45 PM. The clinical record included two plans of care established by a physician for certification period 07/29/15 to 09/05/15 and 09/05/15 to 10/31/15, with orders for skilled nursing visits one to two times a week for nine weeks and home health aide visits for assistance with personal care, meal preparation, medication reminder and light house keeping to maintain a safe and clean environment.

a. The Director of Nurse failed to update the plan of care to reflect the correct certification periods 07/29/15 to 09/26/15 and 09/27/15 to 11/25/15.

b. The Director of Nursing failed to include the frequency and duration of home health aide visits, as well as the type of personal care the home health aide were to provide for both certification periods.

c. Review of the skilled nursing visit notes indicated a recertification assessment had been completed on 09/05/15. The correct certification period was 07/29/15 to 09/26/15. The Director of Nursing failed to complete the recertification assessment within the last 5 days during the 60 day episode.

3. A home visit was made to patient #4 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 32 10/09/15 at 10:30 AM, with the Director of Nursing. During the home visit, the patient was observed to have a wound to the right and left trochanter, left buttock, an area between the left trochanter and left buttock, and left heel. The Director of Nursing proceeded to ask the patient on the type of dressings to be used. The patient had instructed the Director of Nursing to use an AMD Anatomic kerlix roll and directed the Director of Nursing of the location of the dressing. After obtaining the special kerlix roll, the Director of Nursing proceeded to move items around on the bedside table and asked the patient where was the measuring tool so that she may measure his wounds and proceeded to tell the patient that he / she would have to talk her through the dressing. The patient right and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 gauze, took wound cleanser and sprayed over the Q-tip, and proceeded to clean the wound with the Q-tip and then wiped the wound bed with the 4 x 4 gauze. The Director of Nursing then proceeded to take the Q-tip and hovered over the wound then placed the Q-tip over top of the measuring tool on the 4 x 4 package, then placed the Q-tip in the package with the kerlix dressing. The patient was observed to have undermining and tunneled areas in all three wounds and the Director of Nursing failed to measure the undermining and tunneled areas. The Director of Nursing then proceeded to ask the patient if the kerlix needed to be moistened. The patient informed the nurse yes and told the Director of Nursing that Employee H, the routine Registered Nurse / Case Manager, used Normal Saline to moistened the gauze. The Director of Nursing picked up a bottle that was labeled "Derma Gran Wound Cleanser"	G 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 33	G 134		

and informed surveyor that the bottle was Normal Saline. The Director of Nursing then squirted the kerlix gauze three times with the wound cleanser and proceeded to pack the right wound firmly with the kerlix, using the Q-tip that was used for cleaning. After packing the right wound, the Director of Nursing asked the patient if the ABD padding came next but the patient instructed the Director of Nursing that the 4 x 4 gauze came next, and proceeded to tell her how much 4 x 4 gauze to place over the kerlix packing. The Director of Nursing then placed the ABD and then the patient had to instruct the Director of Nursing on placement of the hydrofilm covering. The Director of Nursing proceeds to follow this same procedure and fashion to the left sided wounds, packing them firmly, and asking for direction and guidance from the patient. During the packing of the wound, the patient made facial expressions of discomfort. The patient had to inform the Director of Nursing of the new wound located between the left trochanter and buttocks. The Director of Nursing stated she had not noticed the wound and thanked the patient for pointing the wound out. Moving to the left heel, the Director of Nursing asked the patient what the treatment was that Employee H does to the area. The Director of Nursing proceeds to to ask the patient if Employee H wets the gauze and asked the patient the direction for which to place the gauze. Throughout the dressing change, the Director of Nursing continued to comment on her lack of abilities to perform the dressing change correctly and if she had seen the patient more often, she would be more proficient. The Director of Nursing failed to be prepared, demonstrate and verbalize competence of wound care. After the wound treatments, the Director of Nursing asked the patient what color was the drainage on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 34	G 134		

dressings that he / she had removed prior to our arrival. The Director of Nursing failed to educate the patient not to remove the dressings or to save the dressings in a bag so that the registered nurse may observe the dressings for signs of odor and infection. The was interviewed during this time. The patient had stated he / she was in the hospital in August and again approximately two weeks prior, for a urinary tract infection. The patient stated he / she was discharged with oral antibiotics in August but was not discharged with antibiotics from the recent hospital stay.

a. The clinical record of patient #4, SOC 08/04/15, was reviewed on 10/09/15 at 1:15 PM. The clinical record included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15.

b. The admission paperwork indicated the service was signed and dated by the patient on 08/04/15. The correct certification periods were 08/04/15 to 10/02/15 and 10/03/15 to 12/01/15. The Director of Nursing failed to update the plan of care to reflect the correct start of care date and certification periods.

c. The medication profile on both plans of care indicated the patient was prescribed / taking Clindamycin 150 mg [milligrams], two capsules every eight hours orally, and Bactrim DS 800 mg / 160 mg daily orally. The Director of Nursing failed to update the current plan of care medication profile section to exclude the antibiotics.

d. Both plans of care provided orders for supra pubic catheter changes monthly. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 35	G 134		

Director of Nursing failed to update the plan of care to include interventions for prevention of urinary tract infections, and to include the size and bulb inflation of the suprapubic catheter.

e. Review of the start of care comprehensive assessment dated 08/06/15, documented wounds to two areas on the left hip, an area to the right hip, and an area to the left heel. The treatment indicated wet to dry dressings to "both hips." A resumption of care comprehensive assessment dated 09/03/15, indicated to clean the wounds with wound cleanser, pack with kerlix soaked normal saline, apply ABD, then secure with a transparent dressing. The Director of Nursing failed to update the plan of care to reflect the accuracy of the location of wounds that was being treated, the treatment provided to each wound, and the frequency of dressing changes that were to be preformed.

f. The Director of Nursing wound assessment on the start of care comprehensive assessment dated 08/04/15, indicated the right "hip" wound measured 7 x 5 x 2 cm (centimeters), left hip wounds 5 x 4 x 2 cm and 4 x 4 cm. The Director of Nursing failed to measure the left heal.

g. The patient was hospitalized from 08/30/15 to 09/02/15. A resumption of care comprehensive assessment dated 09/04/15, was performed by the Director of Nursing. The documented wound assessment provided the exact same description and measurements as the start of care comprehensive assessment dated 08/04/15.

h. A skilled nursing visit was made on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 36	G 134		

10/04/15, by Employee H. The right hip measured 12 x 10 x 3 cm, the left hips measured 10 x 10 x 2 cm and 7 x 4 x 2 cm. The new area between the left "hips" measured 2.5 x 2.5 x 2 cm. The left heel measured 1 x 1 x 0.1 cm.

i. A skilled nursing visit was made on 10/09/15, by the Director of Nursing. The right hip measured 6 x 4 x 3 cm, the left hips measured 6 x 5 x 3 cm and 4 x 2 x 3 cm. The wound between the two left "hips" measured 3 x 2 x 0.5 cm, and the left heel measured 2 x 2 cm. The Director of Nursing failed to be accurate in her measures, label the left hips and heel wound correctly, as per previous measurement performed by Employee H.

j. Review of the medication profile indicated the Director of Nursing failed to include a start date of medication ordered, potential side effects, date of drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification.

k. Review of the skilled nursing visit notes, the Director of Nursing failed to complete the recertification assessment within the last 5 days during the 60 day episode.

4. The clinical record for patient #5, SOC 07/31/15, was reviewed on 10/13/15 at 12:00 PM. The clinical record included a plan of care established by a physician for certification period of 07/31/15 to to 09/10/15 and 09/10/15 to 11/05/15.

a. Review of the service agreement indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 37	G 134		

the patient had signed consents for treatment on 07/31/15. The Director of Nursing failed to update the plan of care to reflect the correct certification period of 07/31/15 to 09/28/15 and 09/29/15 to 11/27/15.

b. Review of the medication profile indicated the Director of Nursing failed to include a start date of medication ordered, potential side effects, date of drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification.

c. Review of the skilled nursing visit notes, the Director of Nursing failed to complete the recertification assessment within the last 5 days during the 60 day episode.

5. The clinical record for patient #6, SOC 08/04/15, was reviewed on 10/13/15 at 12:30 PM. The clinical record included a plan of care established by a physician with certification periods of 08/04/15 to 10/25/15, with orders for home health aide services one to four hours per day five days a week for eight week to assist with "ADLs [activities of daily living] and meal prep and light housekeeping to maintain a clean and safe environment." The medication profile indicated the patient was taking "Ferrous Sulfate 1 daily PO [by mouth] and Q Pap 325 mg [milligram] every four hours prn [as needed] for pain."

a. The Director of Nursing failed to update the plan of care to reflect the correct certification periods 08/04/15 to 10/02/15 and failed to specify the ADL duties that the home home health was to provide to the patient. The Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 38	G 134		

failed to include the dosage of the Ferrous Sulfate on the Medication profile.

b. The home health aide written plan of care dated 08/04/15, indicated the home health aide was to observe the patient taking his / her medications. The Director of Nursing failed to update the plan of care to include the medication observation.

c. The start of care comprehensive assessment indicated the patient was on a no salt diet. The plan of care indicated the patient was on a regular diet. The Director of Nursing failed to update the plan of care to include the patient was on a low salt diet.

d. The Director of Nursing failed to develop a plan of care for the certification period of 10/03/15 to 12/01/15.

e. Review of the skilled nursing visit notes, the registered nurse failed to complete the recertification assessment within the last 5 days during the 60 day episode.

f. Review of the medication profile indicated the Director of Nursing failed to include a dosage for the Ferrous Sulfate, failed to include route to the Ferrous Sulfate and Q Pap medications, failed to include potential side effects, a date for the drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification.

6. The clinical record for patient #7, SOC 08/05/15, was reviewed on 10/13/15 at 1:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 39	G 134		

The clinical record included a plan of care established by a physician for certification period of 08/05/15 to to 09/30/15.

a. The failed to Director of Nursing failed to update the plan of care to reflect the correct certification period of 08/05/15 to 10/03/15.

b. The Director of Nursing failed to develop a plan of care for the certification period of 10/04/15 to 12/02/15.

c. Review of the skilled nursing visit notes, the registered nurse failed to complete the recertification assessment within the last 5 days during the 60 day episode.

d. Review of the medication profile indicated the Director of Nursing failed to include the start date and route for all medications, a date for the drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification.

7. The clinical record for patient #8, SOC 09/08/15, was reviewed on 10/13/15 at 1:30 PM. The clinical record included a plan of care established by a physician for certification period of 09/08/15 to to 11/03/15. The Director of Nursing failed to update the plan of care to reflect the correct certification period of 09/08/15 to 11/06/15.

Review of the medication profile indicated the Director of Nursing failed to include the purpose of said medications - oxycontin, amlodipine, aspirin, levetra, omeprazole, atorvastatin, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 40	G 134		

carvedilol as well as the listed side effects, failed to include a date for the drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care.

8. The clinical record for patient #9, SOC 09/30/15, was reviewed on 10/13/15 at 1:43 PM. The clinical record included a plan of care established by a physician for certification period of 09/30/15 to 11/26/15.

a. The Director of Nursing failed to update the plan of care to reflect the correct certification period of 09/30/15 to 11/28/15.

b. Review of the medication profile indicated the patient was taking albuterol sulfate, norvasc, ascorbic acid, aspirin low dose, lipitor, nexium, flonase, gabapentin, cozar, oxycodone/acetaminophen, miralax, and risperdal. The medication section of the plan of care indicated to see the medication profile. The Director of Nursing failed to update the medication section of the plan of care to include the medications that were listed on the medication profile.

c. Review of the medication profile indicated the Director of Nursing failed to include the start date, potential side effects, complete the drug regimen review of the patient / caregiver, and medication reconciliation with the physician, and signed the medication profile with date at the start of care.

9. On 10/13/15 at 3:00 PM, the Director of Nursing employee record was reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 41 a. The Director of Nursing resume indicated that she had not worked since November, 2014. b. Previous experience indicated that the Director of Nursing had been working as an IV [intravenous] nurse for different companies from 2002 to 2014. c. A skilled nursing checklist that was filled out by the Director of Nursing upon hire indicated that her assessment skills, skin care [example: dressing changes], naso-gastric tubes [insertion and care], tracheostomy care, suctioning, oxygen therapy, ventilation care, inhalation treatments, enternal therapy [gastric tube management / care], enema administration, bowel program, removal of fecal impaction, and foley catheter [management / care] was performed more than 12 months ago. d. The first page of the orientation check off indicated that on 06/02/15, the Director of Nursing was read, utilization legal ramification reviewed, and demonstrated comprehension and proficiency in: Steps required to open a home health agency, Home Health Agency Administration [who can fill the position, responsibilities of the position, job description, financial duties, day to day management duties, State and Federal Regulations for this position, Organizational and detailed oriented], Inner workings of the home health agency, Introduction to home care, How to apply for a license, What is CLIA and why you need it, Advance Directives, Advance Directives, Criminal Background checks [Limited and when extended is needed], Home Health Aide registration, Competency evaluation, written test, HIPPA, Coordinated of patient services, OSHA, Accident reporting, and Hepatitis	G 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 42	G 134		

B. The column "Able to Utilize Independently" for each orientation check off had a line through the box.

e. The bottom half of page two of the orientation check off indicated that on 06/03/15, the Director of Nursing read, utilization legal ramifications reviewed, and demonstrated comprehension and proficiency in: personnel files, requires of employment, Licensure for registered nurses, licensed practical nurses, home health aides, and therapists, operational policies, agency forms, clinical policies, HIPPA, Inservices, Employee manual, Patient admission procedure / requirements, and forms. The column "Able to Utilize Independently" for each orientation check off had a line through the box.

f. The top half of page two of the orientation check off indicated that on 06/08/15, the Director of Nursing read, utilization legal ramifications reviewed, and demonstrated comprehension and proficiency in: Blood borne pathogens, Certifications for Medicare, Medicaid, Fee for service, Waiver, TBE [unknown meaning], Who can refer patients, What types of medical providers can the agency accept orders from in and out of state, NPI [National Provider Number], Face to Face, Indiana Administrative Codes for home health agencies, Federal conditions of participation.

The Administrator failed to ensure that the Director of Nursing was properly trained, assessed, and checked off for nursing skills, failed to ensure that the Director of Nursing was properly trained in an extended but reasonable amount of time, to accurately and proficiently perform the duties that is required for the Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 43	G 134		

of Nursing position.

10. The Director of Nursing was interviewed on 10/09/15 at 11:45 AM. The Director of Nursing stated that she had not worked in the office setting for over four years but has been a "hands on" nurse during that time. The Director of Nursing indicated she had not worked in this type of home health setting but has worked for infusion companies. The Director of Nursing indicated that she had been very busy working in the field and at times had a patient load of up to 10 patients in one day. The Director of Nursing stated that she was not able to fulfill her duties in the office and that the Administrator has had to assist her more with hiring, orientation, reference and criminal background checks.

11. The Administrator and Director of Nursing was interviewed on 10/09/15 between 1:10 PM to 1:45 PM. The Administrator stated that the Director of Nursing does all of the admissions, resumption of cares, and recertification assessments, and does the skills check off with the home health aides. The Administrator stated Employee G, the former Director of Nursing, had stepped down to be a case manager in the field on an as needed basis and she was not sure if Employee G or Employee H, a Registered Nurse, had performed the skills check off with the current Director of Nursing. The Administrator and Director of Nursing had nothing further to add in regards to the start of care being the same day consents were signed. The Director of Nursing stated that she had gotten confused and thought the certification period was 30 days. The Administrator stated that the Director of Nursing was hired for the Director of Nursing position because she was a seasoned nurse and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 134	Continued From page 44 some home care experience. At 2:50 PM, the Administrator stated the Director of Nursing does the chart audits. 12. An undated job description titled "Director of Nursing" indicated, " ... Qualifications ... Experience in Home Health or Hospice ... Responsibilities Coordinates and oversees all direct and indirect patient services provided by clinical personnel ... Monitors adherence to policies and procedures ... Coordinates patient records and quality assurance activities ... Audit of patient charts ... Infection control ... Maintain home health standards ... Review of 485 for completion and billing, Quality assurance of discharge charts ... Reviews patient's clinical diagnosis, medications, procedure, and medical course.	G 134		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure that a patient was accepted for services and that the patient needs would be met for 1 of 9 records reviewed (See G 157), failed to ensure visits were made, wound treatment and management was followed in accordance to the plan of care for 4 of 9 records reviewed (See G 158), failed to ensure the plan of care was updated to reflect the correct certification periods, duties of disciplines providing services to the patient, changes in wound treatments, and changes in medications for 7 out of 9 records reviewed (See G 159),	G 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 156	Continued From page 45 failed to notify the physician of a change in the plan of care in relation to a patient changing his / her mind of discharge of services for 1 of 9 records reviewed (See G 164), failed to ensure wound treatments were administered by the skilled nurse as ordered by the physician for 2 of 2 records reviewed on patients with wounds (See G 165), and failed to ensure that verbal orders were put into writing and signed and dated with the date of receipt by the registered nurse for 4 of 9 records reviewed. (See G 166). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision.	G 156		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure that a patient was accepted for services and that the patient needs would be met for 1 of 9 records reviewed. (#1) Findings include: 1. Clinical record #1, SOC (start of care) 07/20/15, include a plan of care established by a	G 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 46	G 157		

physician for certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care and home health aide three hours in the morning and two hours in the evening, 7 days a week. Patient diagnoses included cerebral vascular accident [stroke] with hemiplegia, depression, lymphadema, stasis ulcers, and diabetes.

a. An entry note written in the patient's chart dated 06/11/15, indicated "Made a visit to this patient home ... explained to [Name of patient and spouse] we are a new agency and have a minimum of staff available. We can't give any kind of guarantee that we could provide adequate staff. He / she currently has an aide under waiver from another agency. Told he / she we have one employee in this area but she is only available on a part time basis. [Name of patient and spouse] agreed that anything is better than nothing ... Explained again about very limited staff availability and stated we be attempting to hire someone in the [Name of town] area after admitting her but our staff availability would be very limited .... "

b. An entry note written in the patient's chart dated 08/17/15, indicated "We have received multiple calls since admitting [Name of patient] from the owner and scheduling person at [Name of other agency providing waiver services] about his / her frequent last minute cancellations then calling to demand someone immediately, his / her constant complaining and calling Police, Fire Dept, Prosecutor, APS [Adult Protective Services], and anyone else he / she can think of. They have had multiple aides quit because of the way he / she treats them. They have given him / her notice of discharge and will have very limited

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 47	G 157		

time available to care for him / her until then but will try to."

c. An entry notes written in the patient's chart dated 08/19/15, indicated "8 AM - Call from [Name of patient] states HHA [home health aide] not shown up. He / she is wet - in pain & has UTI [urinary tract infection] & impaction - wants to know when to expect HHA. Told him / her I don't know but would check. Entry signed by the Director of Nursing, a Registered Nurse.

1. 8:15 AM Call from [Name of patient and title of spouse] repeating same info as above told him I just texted his / her HHA & awaiting response." Entry signed by the Director of Nursing.

2 8:30 AM Call from patient & spouse still repeating above info - informed per HHA they had agreed upon time of this afternoon - they said yes they had set up the time but they need someone now - instructed I would try to find someone but I think they are all out seeing other patients I would see if we could get anyone there early." Entry signed by the Director of Nursing.

3. 10 AM [Name of Fire Department] called to inquire if we have anyone going out to care for pt [patient]. Informed them yes we would be sending someone this PM."Entry signed by Director of Nursing.

4. 12 PM Spoke with Employee F to inform her the pt needs to be seen ASAP [as soon as possible] & she said she would get to him / her as soon as she can." Entry signed by the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 48	G 157		

5. 12:30 PM Call from Adult Protective Services - questioning if we had someone going out to see pt today - said yes this PM - caller stated he would like to have a psych consult done on him / her & informed him of MD's involved with pt currently." Entry signed by the Director of Nursing.

d. An entry note written in the patient's chart dated 08/24/15 at 9:24 AM, indicated "Called [Name of pt] to inform him / her we are not going to be able to provide adequate staffing. His / her current caregivers unavailable for most of the days [name of patient] needs care and we have been unable to get an aide to fill the previous caregivers position. We have informed him / her by phone and a letter will go out today 08/24/15 informing him / her of discharge on September 11, 2015. We will make all attempts possible to staff [name of patient] needs in this 2 week interim." Entry signed by the Administrator.

e. An entry note written in the patient's chart dated 08/31/15 at 12:00 PM, indicated the physician had called with an order for a fleets enema to be given. The order was assigned to a registered nurse to administrator later in the day. The entry was signed by the Director of Nursing.

f. An entry note written in the patient's chart dated 09/01/15 at 10:00 AM, indicated "In spite of multiple calls to [name of patient] since 08/24 and a letter stating we are unable to staff her needs due to the fact our 'aide' is taking another job as of 09/07 the patient has sent multiple emails and phone calls accusing us of neglect and abandonment. We have advertised and attempted to find a replacement aide for him / her with no success. Our current staff all refuse to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 49	G 157		

drive that far. We have a difficult time with the number of last minute cancellations and telling staff to leave after they get there and then he / she calls a few hours later demanding we send someone immediately and calls the police, the fire department and APS when we are unable to produce an aide. I received a call from the other agency [name of agency] telling me they are discharging him / her for the same reason. They stated he /she had caused them to loose 8 employees. Dr. Miller is aware of the problem and is seeking psych consult." Entry signed by the Administrator.

g. An entry note written in the patient's chart dated 09/03/15 at 10:20 AM, indicated " ... Upon arriving at their home the patient refused to go inside saying she was impacted and that i could not help him / her and asked me to leave. I verified with the patient that was what he / she wanted and then left. The patient had received an order from her doctor for a fleets enema on 08/31/2015. I was prepared to administer the enema however the patient refused due to the fact I have never given an enema. He / she complained about not having an enema all throughout the week and has refused to let me administer it all along." Entry signed by Employee F, a Registered Nurse who had been providing the patient's home health aide services since admission.

2. Review of the home health aide missed visit notes are as follows:

a. Missed visit report dated 08/03/15 indicated, "No aide available for AM visit. Patient had been advised in advance when admitted of limited staff available but she wanted to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 50	G 157		

forward because she had no caregiver .... " Entry entered by Administrator.

b. Missed visit report dated 08/04/15 indicated, "After deciding with HHA to have all his / her hours at one visit rather than split [Name of patient] called complaining and demanding a second visit. Explained as he / she had been told on admission we had very limited people who would come that far north and there was no one else available .... " Entry entered by Administrator.

c. Missed visit report dated 08/05/15 indicated, "[Name of patient] answered phone and was informed there is no one for eve [evening] vst [visit] .... " Entry entered by Administrator.

d. Missed visit report dated 08/10/15 indicated, "His / her HHA is on vacation and pt is refusing replacement. He / she has an aide from another agency and skilled nurse will try to fill in when she can." Entry entered by Administrator.

e. Missed visit report dated 08/12/15 indicated, "Skilled nurse saw pt in PM and did basic care with skilled visit. Pt had no visit in AM as aide is on vacation and not one will go that far north. Family is aware. Aide from another agency was there." Entry entered by Administrator.

f. Missed visit report dated 08/13/15 indicate, "Skilled nurse there for visit. We have no aide but the aide from another agency is there. Pt call fire dept [department] to transfer her." Entry entered by Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 51	G 157		

g. Missed visit report dated 08/14/15 indicated, "Skilled nurse visit and pt has vst [visit] from DPM [podiatrist] from [Name of physician group]. No aide from other agency or AAHHC [All Ages Home Health Care]. Skilled nurse did basic care for one visit. No second visit .... " Entry entered by Administrator.

h. Missed visit report dated 08/14/15 for visit dates of 08/15/15 to 08/18/15, indicated "Patient informed again that we have no staff available. DPM [Name of Physician] is handling compression dressings through [Name of Medical Group] so no skilled nurse visits .... " Entry entered by Administrator.

i. Missed visit report dated 08/18/15 indicated, "Patient chose to have an extended visit on her caregivers first day back and no PM visit and then called at 4 P [4:00 PM} to complain and demand an evening visit. Explained we have no one to come this PM." Entry entered by Administrator.

j. Missed visit report dated 08/19/15 indicated, "After setting the time she wanted the aide to come as being afternoon patient called to complain about no one there and subsequently cal the fire dept and APS to report she was being neglected. Aide was there as scheduled by patient for PM visit .... " Entry entered by Administrator.

k. Missed visit report dated 08/20/15 indicated, "Patient again set time with caregiver on 08/18 to be at her home in PM on 08/19 and then called on 08/19 in the AM to demand that someone come to her to do her care. Explained the aide is now not available in AM because pt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 52	G 157		

had set a scheduled PM visit." Entry entered by Administrator.

l. Missed visit report dated 08/21/15 indicated, "Called [Name of patient] to inform her we have no one to make her AM visit on 08/23/15. Discussed this also with her caregiver who is going to tell [Name of patient and spouse] she is not available 08/23." Entry entered by Administrator.

m. Missed visit report dated 08/24/15 indicated, "No one available for AM visit. [Spouse] will do his / her care. HHA and the office had informed pt and [spouse] on 08/21 there would no no AM visit on 08/23 yet they called complaining and threatening to report us to any one they could call accusing us of abandonment." Entry entered by Administrator.

n. Missed visit report dated 08/24/15 indicated, "Called [Name of patient and spouse] to let them know their caregiver will not be available for a PM visit on 08/25 and 08/27. Also told his / her the caregiver is leaving for another job on 09/06 and we have no replacement at this time. He / she should look for an alternate agency." Entry entered by Administrator.

o. Missed visit report dated 08/25/15 for visit dates 08/25/15 PM and 08/27/15 PM, indicated "Patient had been informed in advance on 08/24/15 that there would be no one available for the PM visit on 08/25 & 08/27." Entry entered by Administrator.

p. Missed visit report dated 08/27/15 indicated, "Patient had been notified no one would be available for the PM visit." Entry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 53	G 157		

entered by Administrator.

q. Missed visit report dated 08/28/15 for visit date 08/30/15 indicated, "Called patient to tell her no one is available for her AM visit on 08/30/15. We have called all staff members and no one will drive that far north." Entry entered by Administrator.

r. Missed visit report dated 08/31/15 for visit 08/30/15 indicated, "Patient had been informed on 08/28 there would be no one available for the AM visit this day." Entry entered by Administrator.

s. Missed visit report dated 09/01/15 indicated, "Patient has been informed by phone and letter that this caregiver is leaving to take another job and we have been unable to hire an aide after advertising and interviewing. No PM visit today." Entry entered by Administrator.

t. Missed visit report dated 09/07/15 indicated, "No one available for AM vst [visit]. Pt has been told since 08/24 that this person is leaving on 09/07 and we have been unable to find an aide who will drive that far north. They need to pursue another caregiver." Entry entered by Administrator.

u. Missed visit report dated 09/11/15 for visits 09/07 to 09/11/15, indicated "No one has been available for AM or PM visit. We have called daily to let pt and [spouse] know and encourage them to seek another agency since we are unable to staff his / her care." Entry entered by Administrator.

3. The Administrator was interviewed on 10/08/15 at 2:50 PM. The Administrator stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 54	G 157		

the patient and the spouse had been informed prior to admission of their staffing issues and being a new company. The Administrator stated that the patient had refused multiple visits from home health aide, constantly change the hours and then would want assistance without notice. The Administrator stated she was "begged" to take the patient due to multiple agencies had been fired by the patient.

4. The Director of Nursing was interviewed on 10/09/15 at 11:15 AM. The Director of Nursing stated the patient was accepted due to the agency had two home health aides lined up to care for the patient but when the home health aides found out who the patient was, they declined to work for the agency. The Director on Nursing stated that former Employee F was a registered nurse and had temporarily agreed to provide care to the patient as a Home Health Aide when she can and Employee G, a per diem Registered Nurse and Alternate Director of Nursing, agreed to see the patient as the Case Manager. The Director of Nursing indicated she was not able to assist Employee F with the enema on 09/03/15 because she was seeing other patient's and the Administrator was out of town.

5. An undated policy titled Client Admission Process indicated, "Policy ... Services will not be initiated until an initial assessment has been completed and identified client needs can be met by the agency. The agency determines that client needs can be met by the agency ... Purpose ... To determine whether the client's health care needs for services are appropriate by evaluating the client's physical, psychological, social, spiritual, and cultural status. To identify situation in which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 55 the agency will not provide services. Special Instructions: Admission Criteria are standards by which a client can be deemed appropriate for admission. These standards include ... c. The home environment is suitable or adaptable for proper home care. d. The client's needs can safely and adequately be met at home. This includes the ongoing availability of personnel and equipment and a plan to meet medical emergencies. e. Home care services provided in the client's place of residence are within the geographic area served by the agency. f. The Agency is capable of providing the needed care or service at the level of intensity the client's condition requires ... j. The services and care must conform with current professional standards of practice for the respective discipline and should be reasonable and necessary to the treatment of a medical disorder ... 2. Agency will not admit client or continue to provide services in the following situations: a. Scope and complexity of needs cannot be met by agency. b. Skills and suitability of agency personnel are not adequate to meet client needs. c. The client's life situation / caregiver support system does not provide for his / her maintenance and supervision ... 13. If the agency cannot fulfill the required health care need, a referral will be made to other appropriate community resources and referral source will be notified .... "	G 157		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 56 This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure visits were made, wound treatment and management was followed in accordance to the plan of care for 4 of 9 records reviewed. (#1, 3, 5, 7) Findings include: 1. Clinical record #1, SOC (start of care) 07/20/15, include a plan of care established by a physician for certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care and home health aide three hours in the morning and two hours in the evening, 7 days a week. Patient diagnoses included cerebral vascular accident [stroke] with hemiplegia, depression, lymphadema, stasis ulcers, and diabetes. Treatment orders indicated to apply non-adherent dressing and secure with kerlix or similar product. Teach husband to reapply and evaluate wound progress weekly. a. Review of the skilled nursing notes indicated there were no skilled nursing visits between 07/20/15 to 08/03/15, the skilled nurse made one extra visit during week one, two extra visits during week two, and no skilled nursing visits during week four, five, and six. The skilled nurse failed to follow the plan of care. 1. Skilled nursing visit note dated 08/05/15, indicated the nurse was waiting a call back from the physician and that a treatment plan was being developed. The visit note failed to include treatment provided during the visit and that the spouse was educated on management of the wound.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 57 2. Skilled nursing visit note dated 08/12/15, indicated the nurse dressed the wound with a waterproof non-adhesive edge gauze. The skilled nurse failed to follow the current treatment order and failed to indicate if the spouse was educated on the management of the wound. 3. Skilled nursing visit note dated 08/13/15, failed to indicate if kerlix was applied to the wound after applying telfa (non adhering dressing) and failed to indicate if the spouse was educated on the management of the wound. 4. Skilled nursing visit note dated 08/14/15, failed to indicate if the spouse was educated on the management of the wound. b. Review of the Home Health aide visit notes indicated there were no home health aide visits between 07/20/15 to 08/03/15, AM visit were missed on 08/05, 08/07, 08/14, 08/15, 08/16, 08/17, 08/19, 08/23, 08/30, 09/03, 09/07, 09/08, 09/09, 09/10, and 09/11/15. PM visits were missed on 08/06, 08/10,08/15, 08/16, 08/17, 08/22 (only 1 hour provided), 08/24, 08/25, 08/26, 08/27, 08/31, 09/01, 09/02, 09/03, 09/07, 09/08, 09/09, 09/10, and 09/11/15. Visit hours that were combined in one visit on 08/04 (9:30 AM - 2:30 PM), 08/08 (9:00 AM - 1:00 PM), 08/18 (10:30 AM - 2:30 PM), 08/19 (1:00 - 5:15 PM), and 08/20 (9:00 AM - 1:15 PM). 2. Clinical record #3, SOC 11/13/14, included a plan of care established by a physician for certification period of 05/14/15 to 07/13/15, with orders for skilled nursing one time a week for 9 weeks for medication set up, homemaker one hour per week for nine weeks.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 58	G 158		

a. Review of the skilled nursing notes, the skilled nurse failed to make a nursing visit between during week one.

b. Review of the home maker visit notes, the home maker failed to make a visit duirng week one.

3. Clinical record #5, SOC 07/31/15, included a plan of care established by a physician for certification period of 07/31/15 to to 09/10/15, with orders for skilled nursing two to three times a month for two month to assess, medication compliance, safety, home health aide supervision, assess patient's overall health and home health aide services three to four hours a day, three to five days a week to assist with personal care to include partial to complete bath or shower, shampoo, skin care, meal preparation, light housekeeping to help maintain clean and safe environment. Review of the skilled nursing notes, failed to evidence skilled nursing visits 07/31/15 to 09/18/15.

a. The clinical record was reviewed on 10/13/15 at 12:00 PM. A physician order dated 09/03/15, indicated "HHA [home health aide] visits three to five hours per day, three to five days per week. PT [Physical therapy] to restore function based on the following clinical findings, balance problems with household transfers, require therapy. Weakness limiting ability to stand without assist. Require strength training. PT to develop program home health aide can follow .... " Review of the home health aide visit notes on 10/13/15 at 12:00 PM, indicated there were no home health aide visits between 07/31/15 to 09/06/15. Physicial therapy failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 59	G 158		

follow the plan of care.

b. A physician order dated 09/17/15, indicated to "decrease home health aide visits to one hour per day, secondary to Medicaid approval. Increase visits to seven days per week secondary to family weekend coverage not available at this time." Review of the home health aid visits notes, indicated that the home health aid started seeing the patient for one hour per day on 09/13/15. The home health aide failed to follow the plan of care.

c. An interview with the Administrator on 10/13/15 at 12:20 PM, stated that the patient did not start services until after the medicaid prior authorization was approved.

4. Clinical record #7, SOC 08/05/15, included a plan of care established by a physician for certification period of 08/05/15 to to 09/30/15, with orders for skilled nursing one to four times monthly for medication set up and assessment. Review of the skilled nursing notes, failed to evidence skilled nursing visits 08/05/15 to 09/10/15.

5. Clinical record #9, SOC 09/30/15, included a plan of care established by a physician for certification period of 09/30/15 to 11/26/15, with orders for skilled nursing one time a week for nine weeks and home health aide services three to four hours a day, three to five days a week for nine weeks.

a. Review of the skilled nursing visit notes indicated that the skilled nurse made an extra visit during week one. The skilled nurse failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 60 follow the plan of care. b. Review of the home health aide visit notes indicated that the home health aide did not start services until week two on 10/06/15. The home health aide failed to follow the plan of care. 6. The Administrator was interviewed on 10/13/15 at 3:50 PM, and was unable to provide any further documentation and / or information regarding the findings referenced above. 7. An undated policy titled "Registered Nurse" indicated, "Provides direct care and case management for a team of Agency clients in accordance with the state Nurse Practice Act and Agency policy .... "	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the plan of care was updated to reflect the correct certification periods, duties of disciplines providing services to the patient, changes in wound treatments, and current and discontinued	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 61	G 159		

medications for 8 out of 9 records reviewed. (#1, 2, 4, 5, 6, 7, 8, and 9)

Findings include:

1. The clinical record of patient #1 was reviewed on 10/08/15. The clinical record included a plan of care established by a physician for a start of care date of 08/03/15 with a certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care. The treatment ordered on the plan of care indicated for the skilled nurse to apply non-adherent dressing and secure with kerlix or similar product.

a. Review of the service agreement indicated the patient had signed consents for treatment on 07/20/15. The plan of care failed to be updated to reflect the correct start of care date of 07/20/15 and a certification period of 07/20/15 to 09/17/15. The plan of care also failed to include the location of the patient's wound, how to clean the wound, and frequency of dressing changes.

b. An OASIS start of care comprehensive assessment dated 08/03/15, indicated "M2250 Plan of Care Synopsis ... Does the physician - ordered plan of care include the following ... b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient / caregiver education on proper foot care - yes, c. Falls prevention interventions - yes, d. Depression interventions such as medication, referral for other treatment, or a monitoring plan or current treatment and / or physician notified that patient screened positive for depression - yes, e. Interventions to monitor and mitigate pain - yes, f. Interventions to prevent pressure ulcers - yes .... " The plan of care failed to be updated to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 62	G 159		

include interventions listed b - f.

c. The medication portion of the plan of care indicated "see attached medication profile." The plan of care failed to include medications listed on the medication profile that the patient was taking / prescribed.

2. The clinical record of patient #2, SOC 07/29/15, was reviewed on 10/08/15 at 3:45 PM. The clinical record included two plans of care established by a physician for certification period 07/29/15 to 09/05/15 and 09/05/15 to 10/31/15, with orders for home health aide visits for assistance with personal care, meal preparation, medication reminder and light house keeping to maintain a safe and clean environment.

a. The plan of care failed to be updated to reflect the correct certification periods 07/29/15 to 09/26/15 and 09/27/15 to 11/25/15.

b. The agency failed to include the frequency and duration of home health aide visits, as well as the type of personal care the home health aide were to provide for both certification periods.

3. During a home visit on 10/09/15 at 10:30 AM, patient #4 was observed to have a wound to the right and left trochanter, left buttock, and left heel. The patient had stated he / she was in the hospital in August and again approximately two weeks prior, for a urinary tract infection. The patient stated he / she was discharged with oral antibiotics in August but was not discharged with antibiotics from the recent hospital stay. The medication profile listed on both of the plans of care indicated the patient was taking Clindamycin and Bactrim DS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 63	G 159		

a. The clinical record for patient #4, SOC 08/04/15, was reviewed on 10/09/15 at 1:30 PM. The clinical record included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15 with orders for skilled nursing daily for wet to dry dressing changes to "decubes both hips," supra pubic catheter changes monthly.

1. The correct certification periods were 08/04/15 to 10/02/15 and 10/03/15 to 12/01/15. The Registered Nurse failed to update the plan of care to reflect the correct start of care date and certification periods.

2. Review of the start of care comprehensive assessment dated 08/06/15, documented wounds to two areas on the left hip, an area to the right hip, and an area to the left heel. The treatment indicated wet to dry dressings to "both hips." A resumption of care comprehensive assessment dated 09/03/15, indicated to clean the wounds with wound cleanser, pack with kerlix soaked normal saline, apply ABD, then secure with a transparent dressing. The Registered Nurse failed to update the plan of care to reflect the accuracy of the location of wounds that was being treated, the treatment provided to each wound, and the frequency of dressing changes that were to be preformed.

3. The Registered Nurse failed to update the current plan of care medication profile section to exclude the antibiotics, to include interventions for prevention of urinary tract infections, and to include the size and bulb inflation of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 64	G 159		

suprapubic catheter.

4. The clinical record for patient #5, SOC 07/31/15, was reviewed on 10/13/15 at 12:00 PM. The clinical record included a plan of care established by a physician for certification period of 07/31/15 to to 09/10/15 and 09/10/15 to 11/05/15. The plan of care failed to be updated to reflect the correct certification period of 07/31/15 to 09/28/15 and 09/29/15 to 11/27/15.

5. The clinical record for patient #6, SOC 08/04/15, was reviewed on 10/13/15 at 12:30 PM. The clinical record included a plan of care established by a physician with certification periods of 08/04/15 to 10/25/15, with orders for home health aide services one to four hours per day five days a week for eight week to assist with "ADLs [activities of daily living] and meal prep and light housekeeping to maintain a clean and safe environment." The medication profile indicated the patient was taking "Ferrous Sulfate 1 daily PO [by mouth] and Q Pap 325 mg [milligram] every four hours prn [as needed] for pain."

a. The plan of care failed to be updated to reflect the correct certification periods 08/04/15 to 10/02/15 and failed to specify the ADL duties that the home home health was to provide to the patient. The Medication Profile failed to include the dosage of the Ferrous Sulfate.

b. The home health aide written plan of care dated 08/04/15, indicated the home health aide was to observe the patient taking his / her medications. The plan of care failed to be updated to include the medication observation.

c. The start of care comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 65	G 159		

assessment indicated the patient was on a no salt diet. The plan of care indicated the patient was on a regular diet. The plan of care failed to be updated to include the patient was on a low salt diet.

d. The clinical record failed to include an updated plan of care for certification periods of 10/03/15 to 12/01/15.

6. The clinical record for patient #7, SOC 08/05/15, was reviewed on 10/13/15 at 1:00 PM. The clinical record included a plan of care established by a physician for certification period of 08/05/15 to to 09/30/15.

a. The plan of care failed to be updated to reflect the correct certification period of 08/05/15 to 10/03/15.

b. The clinical record failed to include an updated plan of care for certification periods of 10/04/15 to 12/02/15.

7. The clinical record for patient #8, SOC 09/08/15, was reviewed on 10/13/15 at 1:30 PM. The clinical record included a plan of care established by a physician for certification period of 09/08/15 to to 11/03/15. The plan of care failed to be updated to reflect the correct certification period of 09/08/15 to 11/06/15.

8. The clinical record for patient #9, SOC 09/30/15, was reviewed on 10/13/15 at 1:43 PM. The clinical record included a plan of care established by a physician for certification period of 09/30/15 to 11/26/15. The medication section of the plan of care indicated to "see medication profile."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 66	G 159		

a. The plan of care failed to be updated to reflect the correct certification period of 09/30/15 to 11/28/15.

b. Review of the medication profile indicated the patient was taking albuterol sulfate, norvasc, ascorbic acid, aspirin low dose, lipitor, nexium, flonase, gabapentin, cozar, oxycodone/acetaminophen, miralax, and risperdal. The plan of care failed to be updated to include the medications that were listed on the medication profile.

9. The Administrator and Director of Nursing was interviewed on 10/09/15 at 1:30 PM. The Director of Nursing stated that she had thought the certification period was 30 days. The Administrator and Director of Nursing had nothing further to add in regards to the start of care being the same day consents were signed.

10. An undated policy titled "Care Plans," indicated " ... The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty [60] days ...

11. An undated policy titled "Medical Supervision" indicated, " ... The physician orders shall outline the disciplines providing care and the type, frequency, and duration of services to be provided .... "

12. An undated policy titled, "Physician Orders" indicated, " ... All orders for medications must contain the name of the drug, dosage, route of administration, and directions of use .... "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 164	Continued From page 67	G 164		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to notify the physician of a change in the plan of care in relation to a patient changing his / her mind of discharge of services for 1 of 9 records reviewed. (#2) Findings include: 1. Clinical record #2, SOC 07/29/15, included a plan of care established by a physician for certification period 09/05/15 to 10/31/15. a. A physician order dated 09/24/15, indicated "May discharge pt [patient] from all services per his / her request." b. Review of the home health aide visit notes indicated that a home health aide made visits to the patient on 09/30/15 and 10/01/15. c. A nursing entry note dated 10/02/15 at 12:40 PM, stated the patient wanted to be discharged from services immediately. The agency failed to notify the physician that the patient had changed his / her mind about services continuing after 09/24/15 and stopping again on 10/02/15. 2. The Administrator was interviewed on 10/08/15 at 3:45 PM. The Administrator stated	G 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 164	Continued From page 68 the patient requested to be discharged on 09/24/15 but had changed his mind and the discharge order was not canceled. 3. An undated policy titled "Medical Supervision" indicated, " ... Physician will be contacted when any of the following occurs ... e. Any change in client condition or agency services, including non - compliance of the client related to the plan of care .... "	G 164		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure wound treatments were administered by the skilled nurse as ordered by the physician for 2 of 2 records reviewed on patients with wounds. (#1 and 2) Findings include: 1. Clinical record #1, SOC (start of care) 07/20/15, include a plan of care established by a physician for certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care. Patient diagnoses included cerebral vascular accident [stroke] with hemiplegia, depression, lymphadema, stasis ulcers, and diabetes. Treatment orders indicated to apply non-adherent dressing and secure with kerlix or similar product. a. Skilled nursing visit note dated 08/12/15,	G 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 69	G 165		

indicated the nurse dressed the wound with a waterproof non-adhesive edge gauze. The skilled nurse failed to follow the current treatment order.

b. Skilled nursing visit note dated 08/13/15, indicated the nurse changed a Band-Aid to a wound to the 2nd toe on the left foot that was identified on 08/05/15. The skilled nurse failed to obtain an order for treatment of the 2nd toe wound on the left foot.

2. Clinical record #4, SOC 08/04/15, included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15 with orders for skilled nursing daily for wet to dry dressing changes to "decubes both hips."

a. During a home visit on 10/09/15 at 10:30 AM, the Director of Nursing was observed to perform a dressing change to an area between the left trochanter and buttock, as well as the right and left trochanter, left buttock, The Director of Nursing was observed to clean the wounds with q-tips and wound cleanser, wiped the wounds with 4 x 4 gauze, sprayed wound cleanser two to three times to an antimicrobial kerlix vs the traditional kerlix, as instructed by the patient, and firmly packed the right / left trochanter and left buttocks wound, applied the same kerlix to the wound between the left buttocks and trochanter, covered all wounds with ABD pads, and secured the dressings with hydrofilm. The Director of Nursing was also observed to clean the left heal with wound cleanser, applied a dry dressing and secured with cover roll. During the observation, the Director of Nursing confirmed with the patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 70	G 165		

of the treatments being done by Employee H, a Registered Nurse, who routinely sees the patient. The patient had a large box of antimicrobial kerlix in his bedroom.

b. The clinical record was reviewed on 10/09/15 at 1:30 PM. The skilled nursing visit note dated 10/03/15, indicated Employee H observed the patient to have a new wound between the left buttocks and left trochanter. The description provided indicated the wound had slough but no drainage. A skilled nursing notes dated 10/04, 10/05, 10/06, 10/07, and 10/08/15, indicated Employee H provided wound treatment by cleansing the wound with wound cleanser, then applying normal saline wet to dry dressing and secured with cover-roll.

c. Skilled nursing visit notes from 08/06/15 to 08/29/15, 09/03/15 to 09/18/15, and 09/26/15 to 10/09/15, indicated the right / left trochanter and left buttock wounds were being cleaned with wound cleanser, wounds being pack with normal saline wet kerlix, then 4 x 4, ABD padding, and secured with hydrofilm transparent dressing. The left heel was being cleansed with wound cleanser, 4 x 4 normal saline wet to dry, and coverall to secure.

The Director of Nursing and Employee H was providing specific wound treatments, such as wound cleanser, antimicrobial kerlix, ABD, and hydrofilm to the right / left trochanter and left buttocks without a physician's order. The Director of Nursing and Employee H was providing wound treatments to the new pressure area between the left trochanter and buttock as well as the left heel without a physician's order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 165	Continued From page 71 3. The Administrator was unable to provide any further documentation and / or information regarding the findings referenced above by the exit conference on 10/13/15 at 3:50 PM. 4. An undated policy titled "Physician Orders" indicated, "All medications, treatments and services provided to clients must be ordered by a physician.	G 165		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure that verbal orders were put into writing and signed and dated with the date of receipt by the registered nurse for 4 of 9 records reviewed. (#1, 3, 4, and 9) Findings include: 1. Clinical record #1, SOC (start of care) 07/20/15. A skilled nursing visit note dated 08/14/15, indicated "wrap profore drsngs [dressings] & wd [wound] care by their provider - cont [continue] terminate wound care by All Ages HHC [Home Health Care], Inc. Discharge to higher level of care if unable to safely be cared for at home. Wd care lymphadema by [Name of physician group] contracted provider .... "	G 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 166	Continued From page 72 Employee G failed to put the order in writing with signature and date of receipt. 2. Clinical record #3, SOC 11/13/14, included a plan of care established by a physician for certification period of 05/14/15 to 07/13/15. a. Review of the skilled nursing visit notes, the last skilled nursing visit note was 06/11/15. b. Review of the physician orders, an order to discharge the patient was written on 06/29/15. The agency failed to obtain a physician order to discharge within a timely manner. 3. Clinical record #4, SOC 08/04/15. An entry note written by the Administrator on 09/04/15, indicated Employee H had notified the office to report that the patient heel decube had reopened and was resuming the wet to dry dressings to the left heel as ordered. Employee H failed to put the order in writing with signature and date of receipt. 4. Clinical record #9, SOC 09/30/15, included a plan of care established by the physician for the certification period of 09/30/15 to 11/26/15, with orders for skilled nursing one time a week for nine weeks to evaluate left below the knee stump for healing and possible skin breakdown and evaluate ulcer on right "bk" [below the knee] for progression to healing or non healing and increase size. a. Review of the skilled nursing note dated 10/02/15, indicated the skilled nurse provided wound treatment to the right, second toe by cleansing the area with wound cleanser, applying polysporin ointment, applied a dressing and	G 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 166	Continued From page 73	G 166		

secured the dressing by aseptic technique. The nursing note failed to indicate if the physician was contacted for treatment orders.

b. A fax and a physician's order dated 10/05/15, was observed in the front pocket of the patient's record. The comment section of the fax indicated, "Pt [patient] has open area rt [right] great toe. RN applied neosporin ointment over w/E [sic - unknown]. Is there anything else you would like us to do?" The physician order indicated "Please apply neosporin oint [ointment] to open area rt great toe prn [as needed]." The order was signed by the Director of Nursing but failed to include a date of accepting the order.

c. Review of the skilled nursing note dated 10/09/15, indicated the skilled nurse provided wound treatment to the right, second toe by cleansing the area with wound cleanser, applying polysporin ointment, applied a dressing and secured the dressing by aseptic technique.

The Registered failed to obtain a verbal order from the physician prior to performing any wound treatment. The Director of Nursing failed to document the correct ointment, provide the right location of the wound, and failed to provide an accurate frequency of wound care that the Registered Nurse was providing.

5. The Administrator was interviewed on 10/13/15 at 2:00 PM. The Administrator stated that orders located in the front of the patient's record were orders that were waiting for signature from the physician. The Administrator was not able to state if Employee H or the Director of Nursing had obtained verbal orders prior to providing wound treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 166	Continued From page 74 6. An undated policy titled "Physician Orders" indicated, "All medications, treatments and services provided to clients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner ... 1. ... The verbal order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature.	G 166		
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to ensure visits were made and wound treatment and management was followed in accordance to the plan of care for 5 of 9 records reviewed (See G 170), Nurse failed to ensure the plan of care was updated to reflect the correct certification periods, duties of disciplines providing services to the patient, changes in wound treatments, and current and discontinued medications for 6 out of 9 records reviewed (See G 173), and failed to be prepared and knowledgable in providing wound treatment and assessment for 1 of 1 home visits observed and failed to completely assess and document a patient patient's wound for 2 of 3 records reviewed of patients with wound treatments (See G 174). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.30 Nursing	G 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 168	Continued From page 75	G 168		
	Service.			
G 170	484.30 SKILLED NURSING SERVICES	G 170		

The HHA furnishes skilled nursing services in accordance with the plan of care.

This STANDARD is not met as evidenced by:
Based on record review and interview, the Registered Nurse failed to ensure visits were made and wound treatment and management was followed in accordance to the plan of care for 5 of 9 records reviewed. (#1, 3, 5, 7, and 9)

Findings include:

1. Clinical record #1, SOC (start of care) 07/20/15, include a plan of care established by a physician for certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care. Patient diagnoses included cerebral vascular accident [stroke] with hemiplegia, depression, lymphadema, stasis ulcers, and diabetes. Treatment orders indicated to apply non-adherent dressing and secure with kerlix or similar product. Teach husband to reapply and evaluate wound progress weekly.

a. Review of the skilled nursing notes indicated there were no skilled nursing visits between 07/20/15 to 08/03/15, the skilled nurse made one extra visit during week one, two extra visits during week two, and no skilled nursing visits during week four, five, and six. The skilled nurse failed to follow the plan of care.

1. Skilled nursing visit note dated 08/05/15, indicated the nurse was waiting a call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 170	Continued From page 76	G 170		

back from the physician and that a treatment plan was being developed. The visit note failed to include treatment provided during the visit and that the spouse was educated on management of the wound.

2. Skilled nursing visit note dated 08/12/15, indicated the nurse dressed the wound with a waterproof non-adhesive edge gauze. The skilled nurse failed to follow the current treatment order and failed to indicate if the spouse was educated on the management of the wound.

3. Skilled nursing visit note dated 08/13/15, failed to indicate if kerlix was applied to the wound after applying telfa (non adhering dressing) and failed to indicate if the spouse was educated on the management of the wound.

4. Skilled nursing visit note dated 08/14/15, failed to indicate if the spouse was educated on the management of the wound.

2. Clinical record #3, SOC 11/13/14, included a plan of care established by a physician for certification period of 05/14/15 to 07/13/15, with orders for skilled nursing one time a week for 9 weeks for medication set up. Review of the skilled nursing notes, the skilled nurse failed to make a nursing visit between during week one.

3. Clinical record #5, SOC 07/31/15, included a plan of care established by a physician for certification period of 07/31/15 to to 09/10/15, with orders for skilled nursing two to three times a month for two month to assess, medication compliance, safety, home health aide supervision, assess patient's overall health and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 170	Continued From page 77 home health aide services three to four hours a day, three to five days a week to assist with personal care to include partial to complete bath or shower, shampoo, skin care, meal preparation, light housekeeping to help maintain clean and safe environment. Review of the skilled nursing notes, failed to evidence skilled nursing visits 07/31/15 to 09/18/15. 4. Clinical record #7, SOC 08/05/15, included a plan of care established by a physician for certification period of 08/05/15 to to 09/30/15, with orders for skilled nursing one to four times monthly for medication set up and assessment. Review of the skilled nursing notes, failed to evidence skilled nursing visits 08/05/15 to 09/10/15. 5. Clinical record #9, SOC 09/30/15, included a plan of care established by a physician for certification period of 09/30/15 to 11/26/15, with orders for skilled nursing one time a week for nine weeks. Review of the skilled nursing visit notes indicated that the skilled nurse made an extra visit during week one. The skilled nurse failed to follow the plan of care. 6. The Administrator was unable to provide any further documentation and / or information regarding the findings referenced above by the exit conference on 10/13/15 at 3:50 PM. 7. An undated policy titled "Registered Nurse" indicated, "Provides direct care and case management for a team of Agency clients in accordance with the state Nurse Practice Act and Agency policy ...	G 170		
G 173	484.30(a) DUTIES OF THE REGISTERED	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 78	G 173		

NURSE

The registered nurse initiates the plan of care and necessary revisions.

This STANDARD is not met as evidenced by:
Based on record review and interview, the Registered Nurse failed to ensure the plan of care was updated to reflect the correct certification periods, duties of disciplines providing services to the patient, changes in wound treatments, and current and discontinued medications for 6 out of 9 records reviewed. (#1, 2, 3, 5, 6, 7, 8, and 9)

Findings include:

1. Clinical record #1, included a plan of care established by a physician for a start of care date of 08/03/15 with a certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care. The treatment ordered on the plan of care indicated for the skilled nurse to apply non-adherent dressing and secure with kerlix or similar product.

a. The clinical record was reviewed on 10/08/15. Review of the service agreement indicated the patient had signed consents for treatment on 07/20/15. The plan of care failed to be updated to reflect the correct start of care date of 07/20/15 and a certification period of 07/20/15 to 09/17/15. The plan of care also failed to include the location of the patient's wound, how to clean the wound, and frequency of dressing changes.

b. An OASIS start of care comprehensive assessment dated 08/03/15, indicated "M2250

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 79	G 173		

Plan of Care Synopsis ... Does the physician - ordered plan of care include the following ... b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient / caregiver education on proper foot care - yes, c. Falls prevention interventions - yes, d. Depression interventions such as medication, referral for other treatment, or a monitoring plan or current treatment and / or physician notified that patient screened positive for depression - yes, e. Interventions to monitor and mitigate pain - yes, f. Interventions to prevent pressure ulcers - yes .... " The plan of care failed to be updated to include interventions listed b - f.

c. The medication portion of the plan of care indicated "see attached medication profile." The plan of care failed to include medications listed on the medication profile that the patient was taking / prescribed.

2. Clinical record #2, SOC 07/29/15, included two plans of care established by a physician for certification period 07/29/15 to 09/05/15 and 09/05/15 to 10/31/15, with orders for skilled nursing visits one to two times a week for nine weeks and home health aide visits for assistance with personal care, meal preparation, medication reminder and light house keeping to maintain a safe and clean environment.

a. The Registered Nurse failed to update the plan of care to reflect the correct certification periods 07/29/15 to 09/26/15 and 09/27/15 to 11/25/15.

b. The Registered Nurse failed to include the frequency and duration of home health aide visits, as well as the type of personal care the home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 80	G 173		

health aide were to provide for both certification periods.

3. Clinical record #3, SOC 11/13/14, included a plan of care established by a physician for certification period of 05/14/15 to 07/13/15, with orders for a homemaker one hour per week for nine weeks for basic housekeeping to maintain a clean environment and companion one to three hours per day up to five days a week for nine weeks to socialization assistance with letter writing, food preparation, laundry, orientation, and reminders for medication.

Review of the written plan of care titled "All Ages Home Health Care, Inc. Aide / Homemaker / Attendant Care Plan was initiated / dated on 03/06/15. Under the attendant care title, home maker and companion was handwritten / added. Duties that were checked off for the home health aide to provide included, but not limited to, personal hygiene (tub bath, shower, sponge bath, shampoo, [miscellaneous jobs] included shopping, errands, Dr. appointments with "as needed" handwritten under the section. The Registered Nurse failed to be update the plan of care to the include personal hygiene and miscellaneous job duties that were indicated on the "Aide / Homemaker / Attendant Care Plan."

4. Clinical record #5, SOC 07/31/15, included a plan of care established by a physician for certification period of 07/31/15 to to 09/10/15 and 09/10/15 to 11/05/15.

The clinical record was reviewed on 10/13/15 at 12:00 PM. Review of the service agreement indicated the patient had signed consents for treatment on 07/31/15. The plan of care failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 81	G 173		

be updated to reflect the correct certification period of 07/31/15 to 09/28/15 and 09/29/15 to 11/27/15.

5. Clinical record #6, SOC 08/04/15, included a plan of care established by a physician with certification periods of 08/04/15 to 10/25/15, with orders for home health aide services one to four hours per day five days a week for eight week to assist with "ADLs [activities of daily living] and meal prep and light housekeeping to maintain a clean and safe environment." The medication profile indicated the patient was taking "Ferrous Sulfate 1 daily PO [by mouth] and Q Pap 325 mg [milligram] every four hours prn [as needed] for pain."

a. The clinical record was reviewed on 10/13/15 at 12:30 PM. The plan of care failed to be updated to reflect the correct certification periods 08/04/15 to 10/02/15 and failed to specify the ADL duties that the home home health was to provide to the patient. The Medication Profile failed to include the dosage of the Ferrous Sulfate.

b. The home health aide written plan of care dated 08/04/15, indicated the home health aide was to observe the patient taking his / her medications. The plan of care failed to be updated to include the medication observation.

c. The start of care comprehensive assessment indicated the patient was on a no salt diet. The plan of care indicated the patient was on a regular diet. The plan of care failed to be updated to include the patient was on a low salt diet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 82	G 173		

d. The clinical record failed to include an updated plan of care for certification periods of 10/03/15 to 12/01/15.

6. Clinical record #7, SOC 08/05/15, included a plan of care established by a physician for certification period of 08/05/15 to to 09/30/15.

The clinical record was reviewed on 10/13/15 at 1:00 PM. The plan of care failed to be updated to reflect the correct certification period of 08/05/15 to 10/03/15. The clinical record failed to include an updated plan of care for certification periods of 10/04/15 to 12/02/15.

7. Clinical record #8, SOC 09/08/15, included a plan of care established by a physician for certification period of 09/08/15 to to 11/03/15.

The clinical record was reviewed on 10/13/15 at 1:30 PM. The plan of care failed to be updated to reflect the correct certification period of 09/08/15 to 11/06/15.

8. Clinical record #9, SOC 09/30/15, included a plan of care established by a physician for certification period of 09/30/15 to 11/26/15.

a. The clinical record was reviewed on 10/13/15 at 1:43 PM. The plan of care failed to be updated to reflect the correct certification period of 09/30/15 to 11/28/15.

b. Review of the medication profile indicated the patient was taking albuterol sulfate, norvasc, ascorbic acid, aspirin low dose, lipitor, nexium, flonase, gabapentin, cozar, oxycodone/acetaminophen, miralax, and risperdal. The medication section of the plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 83 care indicated to see the medication profile. The plan of care failed to be updated to include the medications that were listed on the medication profile. 9. The Administrator and Director of Nursing was interviewed on 10/09/15 at 1:30 PM. The Director of Nursing stated that she had thought the certification period was 30 days. The Administrator and Director of Nursing had nothing further to add in regards to the start of care being the same day consents were signed. 10. An undated policy titled "Care Plans," indicated " ... The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty [60] days ... 11. An undated policy titled "Medical Supervision" indicated, " ... The physician orders shall outline the disciplines providing care and the type, frequency, and duration of services to be provided .... "	G 173		
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. This STANDARD is not met as evidenced by: Based on Article 2 of the Indiana Administrative Code, observation, record review and interview, the Registered Nurses failed to be prepared and knowledgeable in providing wound treatment and assessment for 1 of 1 home visits observed and	G 174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 84 failed to completely assess and document a patient patient's wound for 2 of 3 records reviewed of patients with wound treatments. (#4 and 9) Findings include: 1. Article 2. Standards for the Competent Practice of Rule 2. Registered Nursing. 848 IAC (Indiana Administrative Code) 2 - 2 -1 Responsible to apply the nursing process. Sec. 1. The registered nurse shall do the following: (1) Assess the patient / client in a systematic, organized manner ... (4) Implement strategies to provide for patient / client participation in health promotion, maintenance, and restoration. (5) Initiate nursing actions to assist the patient / client to maximize his or her health capabilities ... (7) Seek educational resources and create learning experiences to enhance and maintain current knowledge and skills for his or her continuing competence in nursing practice and individual professional growth. 848 IAC 2 - 2 - 2 Responsibility as a member of the nursing profession. Sec. 1. The registered nurse shall do the following: (1) Function within the legal boundaries of nursing practice based on the knowledge of statutes and rules governing nursing. (2) Accept responsibility for individual nursing actions and continued competence. (3) Communicate, collaborate, and function with other members of the health team to provide safe and effective care. (4) Seek education and supervision as necessary when implementing nursing practice techniques ... 848 IAC 2 - 2 - 3 Unprofessional conduct Sec. 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing nursing practice, which could	G 174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 85	G 174		

jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (1) Using unsafe judgment, technical skills, or inappropriate behaviors in providing nursing care. (2) Performing any nursing technique or procedure for which the nurse is unprepared by education or experience .... "

2. Clinical record #4, SOC 08/04/15, included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15 with orders for skilled nursing daily for wet to dry dressing changes to "decubes both hips."

a. During a home visit on 10/09/15 at 10:30 AM, with the Director of Nursing, the patient was observed to have a wound to the right and left trochanter, left buttock, an area between the left trochanter and left buttock, and left heel. The Director of Nursing proceeded to ask the patient on the type of dressing to be used. The patient had instructed the Director of Nursing to use an AMD Anatomic kerlix roll and directed the Director of Nursing of the location of the dressing. After obtaining the special kerlix roll, the Director of Nursing proceeded to move items around on the bedside table and asked the patient where was the measuring tool so that she may measure his wounds and proceeded to tell the patient that he / she would have to talk her through the dressing. The patient right and left trochanter and left hip wounds were a stage IV and large in size in regards to length and width. The Director of Nursing was observed to place a Q-tip on 4 x 4 gauze, took wound cleanser and sprayed over the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 86	G 174		

Q-tip, and proceeded to clean the wound with the Q-tip and then wiped the wound bed with the 4 x 4 gauze. The Director of Nursing then proceeded to take the Q-tip and hovered over the wound then placed the Q-tip over top of the measuring tool on the 4 x 4 package, then placed the Q-tip in the package with the kerlix dressing. The patient was observed to have undermining and tunneled areas in all three wounds and the Director of Nursing failed to measure the undermining and tunneled areas.

The Director of Nursing then proceeded to ask the patient if the kerlix needed to be moistened. The patient informed the nurse yes and told the Director of Nursing that Employee H, the routine Registered Nurse / Case Manager, used Normal Saline to moistened the gauze. The Director of Nursing picked up a bottle that was labeled "Derma Gran Wound Cleanser" and informed surveyor that the bottle was Normal Saline. The Director of Nursing then squirted the kerlix gauze three times with the wound cleanser and proceeded to pack the right wound firmly with the kerlix, using the Q-tip that was used for cleaning. After packing the right wound, the Director of Nursing asked the patient if the ABD padding came next but the patient instructed the Director of Nursing that the 4 x 4 gauze came next, and proceeded to tell her how much 4 x 4 gauze to place over the kerlix packing. The Director of Nursing then placed the ABD and then the patient had to instruct the Director of Nursing on placement of the hydrofilm covering. The Director of Nursing proceeds to follow this same procedure and fashion to the left sided wounds, packing them firmly, and asking for direction and guidance from the patient. During the packing of the wound, the patient made facial expressions of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 87	G 174		

discomfort. The patient had to inform the Director of Nursing of the new wound located between the left trochanter and buttocks. The Director of Nursing stated she had not noticed the wound and thanked the patient for pointing the wound out. Moving to the left heel, the Director of Nursing asked the patient what the treatment was that Employee H does to the area. The Director of Nursing proceeds to to ask the patient if Employee H wets the gauze and asked the patient the direction for which to place the gauze. Throughout the dressing change, the Director of Nursing continued to comment on her lack of abilities to perform the dressing change correctly and if she had seen the patient more often, she would be more proficient. The Director of Nursing failed to be prepared, demonstrate and verbalize competence of wound care.

After the wound treatments, the Director of Nursing asked the patient what color was the drainage on the dressings that he / she had removed prior to our arrival. The Director of Nursing failed to educate the patient not to remove the dressings or to save the dressings in a bag so that the registered nurse may observe the dressings for signs of odor and infection.

b. The clinical record of patient #4's was reviewed on 10/09/15 at 1:15 PM. The Director of Nursing wound assessment on the start of care comprehensive assessment dated 08/04/15, indicated the right "hip" wound measured 7 x 5 x 2 cm (centimeters), left hip wounds 5 x 4 x 2 cm and 4 x 4 cm. The left heal failed to be measured.

c. A skilled nursing visit was made on 08/13/15, by Employee H. Two of the four

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 88	G 174		

wounds was measured. The right hip measured 18 x 8 x 3 cm and one of the left hip wounds 5 x 6 x 3 cm. The second hip wound and left heal failed to be measured. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

d. A skilled nursing visit was made on 08/14/15, by Employee H. The right hip measured 18 x 10 x 2 cm, the left hips measured 3 x 4 x 2 and 5 x 4 x 2 cm. The left heel measured 2 x 2 x 0.3 cm. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

e. A skilled nursing visit was made on 08/18/15, by Employee H. The right hip measured 18 x 15 x 3 cm, the left hips measured 3.5 x 3 x 1 cm and 5.1 x 4.0 cm. The left heel measured 1 x 1 x 0.1 cm. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

f. A skilled nursing visit was made on 08/24/15, by Employee H. The right hip measured 17 x 15 x 3 cm, the left hips measured 3 x 3 x 2.1 cm, 4 x 4 x 3.5 cm. The left heel measured 1.5 x 1 x 2.1 cm. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

g. The patient was hospitalized from 08/30/15 to 09/02/15. A resumption of care comprehensive assessment dated 09/04/15, was performed by the Director of Nursing. The documented wound assessment provided the exact same description and measurements as the start of care comprehensive assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 89	G 174		

dated 08/04/15.

h. An note in the patient's chart dated 09/04/15, was entered by the Administrator. The entry indicated that Employee H had "called to report that patients heel decube had reopened and was resuming the wet to dry dressings to left heel as ordered."

i. Review of the skilled nursing visit notes dated 09/05/15 to 09/14/15, the left heel was not included / documented in the daily wound wound treatments.

j. A skilled nursing visit was made on 09/07/15, by Employee H. The right hip measured 17 x 15 x 2 cm, the left hips measured 4 x 4.1 x 2 cm and 5 x 4.5 x 3.9 cm. The left heal wound failed to be measured.

k. A skilled nursing visit was made on 09/18/15, by Employee H. The right hip measured 18 x 14 x 3 cm, the left hips measured 15 x 14 x 2 cm and 8 x 9 x 3 cm. The left heal wound failed to be measured. The nursing note failed to document if the physician was notified of the significant increase in size of the right hip wound.

l. The patient was hospitalized from 09/19/15 to 09/25/15. The clinical record failed to include a comprehensive assessment upon return from the hospital to include wound measurements and description.

m. A skilled nursing visit was made on 10/3/15, by Employee H. Employee H indicated the patient had a "decube open lt [light slough], no drainage and failed to provide measurements

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 90	G 174		

of the new wound, appearance of surrounding tissue. Skilled nursing visits from 09/26/15 to 10/02/15, failed to indicate that the patient was developing a pressure ulcer prior to eruption of skin on 10/03/15.

n. A skilled nursing visit was made on 10/04/15, by Employee H. The right hip measured 12 x 10 x 3 cm, the left hips measured 10 x 10 x 2 cm and 7 x 4 x 2 cm. The new area between the left "hips" measured 2.5 x 2.5 x 2 cm. The left heel measured 1 x 1 x 0.1 cm.

o. A skilled nursing visit was made on 10/09/15, by the Director of Nursing. The right hip measured 6 x 4 x 3 cm, the left hips measured 6 x 5 x 3 cm and 4 x 2 x 3 cm. The wound between the two left "hips" measured 3 x 2 x 0.5 cm, and the left heel measured 2 x 2 cm. The Director of Nursing failed to be accurate in her measures, label the left hips and heel wound correctly, as per previous measurement performed by Employee H.

Skilled nursing visit notes dated 08/06/15 to 08/29/15, 09/04/15 to 09/18/15, and 09/26/15 to 10/08/15, Employee H, indicated that the wounds were light pink with white - yellow slough tissue or partial granulation. Employee H failed to be document specific descriptions for each wound that provides location and percentage of pink to white tissue and slough, as well as the appearance of surrounding skin around each wound.

3. Clinical record #9, SOC 09/30/15, included a plan of care established by the physician for the certification period of 09/30/15 to 11/26/15, with orders for skilled nursing one time a week for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 91	G 174		

nine weeks to evaluate left below the knee stump for healing and possible skin breakdown and evaluate ulcer on right "bk" [below the knee] for progression to healing or non healing and increase size.

a. Review of the OASIS start of care comprehensive assessment dated 09/30/15, M1330 under the Integumentary Status, indicated the patient had a stasis ulcer that was unobservable and M1340 indicated the patient had an observable surgical wound that was fully granulating. The comprehensive assessment failed to include location, size, and description of the surgical incision and failed to include location of the stasis ulcer and reason for the ulcer to be unobservable.

b. Review of the skilled nursing notes dated 10/02/15, indicated the patient had an open wound to the right toe but failed to include an assessment of the surgical wound that was indicated in the comprehensive assessment.

4. The Director of Nursing was interviewed on 10/09/15 at 11:45 AM. The Director of Nursing stated that she had not worked as a nurse since November, 2014 and she had been an infusion nurse for many years.

5. The Administrator was interviewed on 10/09/15 at 1:30 PM. The Administrator stated Employee G, the former Director of Nursing, had stepped down to be a case manager in the field on an as needed basis and she was not sure if Employee G or Employee H, a Registered Nurse, had performed the skills check off with the current Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 174	Continued From page 92 6. The Director of Nursing personnel record was reviewed on 10/13/15 at 3:00 PM. The Director of Nursing indicated in her proficiency of wound care, that it had been more than 12 months since she had provided wound care. The personnel record failed to include a skills check off for wound care care by the agency after the Director of Nursing was hired. 7. An undated policy titled "Skilled Nursing Services", indicated "The registered nurse ... Provides services requiring specialized nursing skill .... " 8. An undated policy titled "Registered Nurse" indicated, "Provides direct care and case management for a team of Agency clients in accordance with the state Nurse Practice Act and Agency policy .... "	G 174		
G 202	484.36 HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by: Based on record review and interview, the home health aide failed to ensure written plans of care were designed and updated for the appropriate discipline, included dietary restrictions, and written plans of care were written for specific times of day for 4 of 7 records reviewed with home health aide services (See G 224), failed to ensure visits were made and services provided in accordance to the plan of care for 5 of 7 records reviewed with home health aide services (See G 225), and failed to ensure services were to be provided within the homemaker / companion scope of practice for 1 of 2 records reviewed of patients receiving homemaker and / or	G 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 202	Continued From page 93 companion services (See G 227). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.36 Home Health Aide.	G 202		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure written plans of care were designed and updated for the appropriate discipline, included dietary restrictions, and written plans of care were written for specific times of day for 4 of 8 records reviewed with home health aide services. (#1, 3, 4, 6) Findings include: 1. Clinical record #1, SOC (start of care) 07/20/15, included a plan of care established by the physician for the certification period of 08/03/15 to 10/03/15 for home health aide services three hours in the morning 7 days a week to bathe patient, skin care secondary to incontinence of bowel and bladder, dress, diaper, hair care, transfer to wheelchair, prepare breakfast and two hours in the evening 7 days a week to provide skin care secondary to	G 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	Continued From page 94	G 224		

incontinence of bowel and bladder, clean dry diaper, partial to complete bath as needed, transfer to bed. The agency failed to provide a written plan of care for the morning and for the evening home health aide services that was specified within the established plan of care.

2. Clinical record #3, SOC 11/13/14, include a plan of care established by a physician for certification period of 05/14/15 to 07/13/15, with orders for a homemaker one hour per week for nine weeks for basic housekeeping to maintain a clean environment and companion one to three hours per day up to five days a week for nine weeks to socialization assistance with letter writing, food preparation, laundry, orientation, and reminders for medication.

a. Review of the physician orders, the home health aide was discontinued on 12/01/14.

b. Review of the written plan of care titled "All Ages Home Health Care, Inc. Aide / Homemaker / Attendant Care Plan was initiated / dated on 03/06/15. Under the attendant care title, home maker and companion was handwritten. Duties include Personal hygiene (tub bath, shower, sponge bath, shampoo. "Standing assist" was hand written under this section. Housekeeping included dust, vacuum, clean bathroom, clean bedroom, wash clothes, wash linens, and wash dishes. "As needed" was written under "wash dishes". Meal Prep included breakfast, lunch, supper, snacks. Medication included observation. Miscellaneous jobs included shopping, errands, Dr. appointments with "as needed" handwritten under the section. The written plan of care failed to be updated with correct duties that only a home maker and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	Continued From page 95	G 224		

companion may perform within their scope of practice and as ordered by the established plan of care.

3. Clinical record #4, SOC 0807//06/15, included a plan of care established by a physician with certification periods of 09/26/15 to 11/07/15, with orders for home health aide services four hours a day, seven days a week for bathing, skin care and maintain a safe and clean environment.

a. During a home visit on 10/09/15 at 10:30 AM, the patient stated that he / she bathes himself / herself and the home health aide comes daily from 5:00 - 9:00 PM for housekeeping. The apartment appeared to be disorganized and unkept. At the conclusion of the visit, the patient dressed him / herself, and proceeded to go outside where he / she was observed wheeling him / herself around the apartment parking lot.

b. Review of the home health aide written plan of care dated 08/06/15, indicated the home health aide was to provide personal hygiene such as tub bath, shower, hair care, skin care, oral hygiene, and shave. Housekeeping duties included clean bathroom and wash dishes as well as meal prep. The written plan of care failed to be updated with actual duties that meets the patient's needs.

4. Clinical record #6, SOC 08/04/15, included a plan of care established by a physician with certification periods of 08/04/15 to 10/25/15, with orders for home health aide services one to four hours per day five days a week for eight week to assist with "ADLs [activities of daily living] and meal prep and light housekeeping to maintain a clean and safe environment." The start of care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	Continued From page 96 comprehensive assessment indicated the patient was on a no salt diet. The home health aide written plan of care dated 08/04/15, failed to include the patient was on a low salt diet. 4. The Administrator was unable to provide additional information and / or documentation by the exit conference on 10/13/15 at 3:50 PM 5. An undated policy titled "Home Health Aide Services" indicated, " ... The nurse or therapist assesses the need for personal care services and includes the services in the physician plan of care [orders]. A specific care plan is developed documenting the Aide services to be provided .... " 6. An undated policy titled "Home Health Aide: Assignment" indicated, " ... the assignment of tasks will be identified in the home health aide care plan / Assignment Sheet .... "	G 224		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review and interview, the home health aide failed to ensure visits were made and services provided in accordance to the plan of care for 5 of 7 records reviewed with home health aide services. (#1, 2, 4, 5, and 8)	G 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 97	G 225		

Findings include:

1. Clinical record #1, SOC (start of care) 07/20/15, include a plan of care established by a physician for certification period of 08/03/15 to 10/03/15, with orders for home health aide services three hours in the morning 7 days a week to bathe patient, skin care secondary to incontinence of bowel and bladder, dress, diaper, hair care, transfer to wheelchair, prepare breakfast and two hours in the evening 7 days a week to provide skin care secondary to incontinece of bowel and bladder, clean dry diaper, partial to comlete bath as needed, transfer to bed. Patient diagnoses included cerebral vascular accident [stroke] with hemiplegia, depression, lymphadema, stasis ulcers, and diabetes.

a. Review of the Home Health aide visit notes indicated there were no home health aide visits between 07/20/15 to 08/03/15, AM visit were missed on 08/05, 08/07, 08/14, 08/15, 08/16, 08/17, 08/19, 08/23, 08/30, 09/03, 09/07, 09/08, 09/09, 09/10, and 09/11/15. PM visits were missed on 08/06, 08/10,08/15, 08/16, 08/17, 08/22 (only 1 hour provided), 08/24, 08/25, 08/26, 08/27, 08/31, 09/01, 09/02, 09/03, 09/07, 09/08, 09/09, 09/10, and 09/11/15. Visit hours that were combined in one visit on 08/04 (9:30 AM - 2:30 PM), 08/08 (9:00 AM - 1:00 PM), 08/18 (10:30 AM - 2:30 PM), 08/19 (1:00 - 5:15 PM), and 08/20 (9:00 AM - 1:15 PM). The home health aide failed to follow the plan of care.

b. The following home health aide services was provided by Employee *, a registered nurse, who was acting as the home health aide:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 98 1. 08/03 the employee did the laundry and did garbage removal. The employee did not indicate if the bathroom was cleaned. The employee did not follow the plan of care. 2. 08/04, the employee cleaned the kitchen, laundry, changed the bed / made the bed, washed dishes, garbage removal and dusted. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care. 3. 08/05, the employee did the laundry, changed bed / made bed, and garbage removal. The employee did not indicate if the bathroom was cleaned. The employee did not follow the plan of care. 4. 08/06, the employee did the laundry and garbage removal. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care. 5. 08/07, the employee did the laundry and garbage removal. The employee did not follow the plan of care. 6. 08/08, the employee cleaned the kitchen, laundry, changed the bed / made the bed, washed dishes, and garbage removal. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care. 7. 08/09, the employee did the laundry, dusted and mopped. The employee did not indicate if a meal was prepared or if hair care had been provided with the morning care. The employee did not follow the plan of care. 8. 08/10, the employee did the laundry, washed dishes, and garbaged removal. The employee did not indicate if a meal was prepared or if hair care had been provided with the morning care. The employee did not follow the plan of	G 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 99	G 225		

care.

9. 08/18, the employee did the laundry, changed bed / made bed, garbage removal, vaccuumed, and mopped. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

10. 08/19, the employee did the laundry, changed bed / made bed, and garbage removal. The employee did not indicate if a meal was prepared and if the bathroom was cleaned.

11. 08/20, the employee did laundry, washed dishes, garbage removal, vaccuuming, and dusted. The employee did not indicate if a meal was prepared and if the bathroom was cleaned.

12. 08/21, the employee did the laundry, changed bed / made bed, garbage removal, vaccuumed, and mopped. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

13. 08/22, the employee did the laundry, change bed / made bed, and garbage removal. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

14. 08/23, the employee did the laundry, washed dishes, and garbage removal. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

15. 08/24, the employee did laundry, change bed / made bed, garbage removal, dusted, vaccuumed, and mopped. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

16. 08/25, the employee did laundry,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 100	G 225		

change bed / made bed, and garbage removal. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

17. 08/26, the employee cleaned the kitchen, did laundry, change bed / made bed, garbage removal, vaccuumed, and mopped. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

18. 08/27, the employee did laundry, change bed / made bed, vaccuumed, and dusted. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

19. 08/28, the employee did laundry, changed bed / made bed, washed dishes, and garbage removal. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

20. 08/29, the employee did laundry, changed bed / made bed, garbage removal, vaccummed, and dusted. The employee did not indicate if a meal was prepared and if the bathroom was cleaned. The employee did not follow the plan of care.

21. 08/30, the employee did laundry, changed bed / made bed, garbage removal, and mopped. The employee did not follow the plan of care.

22. 08/31, the employee did laudry, garbage removal, and vaccuumed. The employee did not indicate if hair care was provided, a meal was prepared, and if the bathroom was cleaned. The employee did not follow the plan of care.

23. 09/01, the employee did laundry, garbage removal, vaccuumed and mopped. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 101	G 225		

employee did not indicate if a meal was prepared, and if the bathroom was cleaned. The employee did not follow the plan of care.

24. 09/02, the employee changed bed / made bed and garbage removal. The employee did not indicate hair care was provided, a meal was prepared, and if the bathroom was cleaned. The employee did not follow the plan of care.

25. 09/04, the employee did laundry, changed bed / made bed, garbage removal, and mopped. The employee did not indicate hair care was provided, a meal was prepared, and if the bathroom was cleaned. The employee did not follow the plan of care.

23. 09/05, the employee did laundry, changed bed / made bed, garbage removal, vaccuumed, and dusted. The employee did not follow the plan of care.

24. 09/06, the employee did the laundry, change bed / made bed, garbage removal, and mopped. The employee did not follow the plan of care.

2. Clinical record #2, SOC 07/29/15, included two plans of care established by a physician for certification period 07/29/15 to 09/05/15 and 09/05/15 to 10/31/15 with orders for home health aide to assistance with personal care, meal preparation, medication reminder and light house keeping to maintain a safe and clean environment.

a. Review of the home health aide visit notes dated 09/11, 09/14, 09/15, 09/16, 09/17, 09/30, 10/01/15, the home health aide failed to indicate if the patient was provided or declined bathing and hygeine on all visits. The home health aide failed to follow the plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 102	G 225		

b. On 09/11/15 and 09/14/15 home health aide visit note, the aide indicated that she had ran errands for the patient. The home health aid failed to follow the plan of care.

3. Clinical record #4, SOC 08/04/15, included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15 with orders for home health aide services daily for bathing, skin care, and maintain a safe and clean environment.

a. During a home visit on 10/09/15 at 10:30 AM, the patient stated that he / she bathes himself / herself and the home health aide comes daily from 5:00 - 9:00 PM for housekeeping. The apartment appeared to be disorganized and unkept. At the conclusion of the visit, the patient dressed him / herself, and proceeded to go outside where he / she was observed wheeling him / herself around the apartment parking lot.

b. Review of the home health aide written plan of care dated 08/06/15, indicated the home health aide was to provide personal hygiene such as tub bath, shower, hair care, skin care, oral hygiene, and shave. Housekeeping duties included clean bathroom and wash dishes as well as meal prep.

c. Review of the home health aide visit notes, the home health aide started visits with the patient on 08/05/15. Visit records from 08/05/15 to 08/28/15, 09/03/15 to 09/18/15, and 09/26/15 to 10/03/15, included but not limited to, perineal care only, assisted with dressing, prepared and served meal, cleaned the kitchen, did laundry, changed bed / made bed, garbage removal,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 103	G 225		

dusted, vaccuumed, mopped, and ran errands. The home health aide failed to follow the plan of care / written plan of care.

4. Clinical record #5, SOC 07/31/15, included a plan of care established by a physician for certification period of 07/31/15 to to 09/10/15, with orders for home health aide services three to four hours a day, three to five days a week to assist with personal care to include partial to complete bath or shower, shampoo, skin care, meal preparation, light housekeeping to help maintain clean and safe environment.

a. The clinical record was reviewed on 10/13/15 at 12:00 PM. A physician order dated 09/03/15, indicated "HHA [home health aide] visits three to five hours per day, three to five days per week. Review of the home health aide visit notes on 10/13/15 at 12:00 PM, indicated there were no home health aide visits between 07/31/15 to 09/06/15.

b. A physician order dated 09/17/15, indicated to "decrease home health aide visits to one hour per day, secondary to Medicaid approval. Increase visits to seven days per week secondary to family weekend coverage not available at this time." Review of the home health aid visits notes, indicated that the home health aid started seeing the patient for one hour per day on 09/13/15. The home health aide failed to follow the plan of care.

5. Clinical record #8, SOC 09/08/15, included a plan of care established by a physician for certification period of 09/08/15 to to 11/03/15, with orders for home health aide one to two hours a day, three to five days a week up to ten hours per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 104	G 225		

week to assist with personnal care / ADLs (activities of daily living) and to include partial / complete bath, shower, skin care, meal prep and light housekeeping to help keep a safe and clean environment.

a. The clinical record was reviewed on 10/13/15 at 1:30 PM. The home health aide visit notes dated 09/09, 09/10, and 09/11/15, failed to indicate if a meal had been prepared and if light housekeeping had been done or if the patient had declined both services. The home health aide failed to follow the plan of care.

b. Review of the home health aide visit notes dated 09/14, 09/15, 09/16, 09/17, 09/18, 09/21, 09/22, 09/23, 09/24, 09/25, 09/28, 09/29, 09/30, 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, and 10/10/15, failed to indicate if a meal had been prepared or if the patient had declined the service. The home health aide failed to follow the plan of care.

6. On 10/13/15 at 10:00 AM, the Administrator stated that she had spoken with the home health aide for patient #4, and that the patient does bathe himself prior to the nurses arrival for wound care, and the home health aide will assist the patient when needed during her evening visits.

7. An undated policy titled "Home Health Aide Services" indicated, " ... The duties of a home health aide include the provision of hands-on personal care ... The Aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising Nurse / therapist .... "

8. An undated policy titled "Home Health Aide:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 105 Documentation" indicated, "Home Health Aides will document care / services provided on the home health aide charting form. Care / Services provided should be in accordance with direction provided in the Home Health Aide Care Plan .... "	G 225		
G 227	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Any home health aide services offered by an HHA must be provided by a qualified home health aide. This STANDARD is not met as evidenced by: Based on record review and interview, the agency to ensure services were to be provided within the homemaker / companion scope of practice for 1 of 2 records reviewed of patients receiving homemaker and / or companion services. Findings include: 1. Clinical record #3, SOC 11/13/14, included a plan of care established by a physician for certification period of 05/14/15 to 07/13/15, with orders for a homemaker one hour per week for nine weeks for basic housekeeping to maintain a clean environment and companion one to three hours per day up to five days a week for nine weeks to socialization assistance with letter writing, food preparation, laundry, orientation, and reminders for medication. Review of the written plan of care titled "All Ages Home Health Care, Inc. Aide / Homemaker / Attendant Care Plan was initiated / dated on 03/06/15. Under the attendant care title, home maker and companion was handwritten / added.	G 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 227	Continued From page 106 Duties that were checked off for the homemaker / attendant to provide included, but not limited to, personal hygiene (tub bath, shower, sponge bath, shampoo. The written plan of care failed to be updated to exclude personal hygiene that was indicated on the "Aide / Homemaker / Attendant Care Plan." 2. The Administrator was unable to provide additional information and / or documentation by the exit conference on 10/13/15 at 3:50 PM.	G 227		
G 235	484.48 CLINICAL RECORDS This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure that a clinical record was authentic and transcribed by the visiting nurse for 1 of 9 records reviewed. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Clinical Records.	G 235		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.	G 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 107	G 236		

This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to ensure that a clinical record was authentic and transcribed by the visiting nurse for 1 of 9 records reviewed. (# 1)

1. Clinical record #1, SOC (start of care) 07/20/15, included a plan of care established by the physician for the certification period of 08/03/15 to 10/03/15

a. A comprehensive nursing assessment dated 08/03/15, was performed by the Director of Nursing. Most of the OASIS start of care comprehensive assessment was filled out by the Director of Nursing. On page 4 of the assessment in the comment section under prognosis, a different type of handwriting was observed and indicated, "This patient in [sic] non-compliant and manipulative. Treats care staff as 'whipping boy' and staff will not stay."

b. A verbal order dated 08/03/15, was written by Employee G. The verbal order indicated to admit the patient to home care.

c. The plan of care line #23 indicated the Director of Nursing obtained a verbal for start of care.

d. A skilled nursing visit dated 08/05/15 was made by Employee G who indicated she was waiting for a return phone call by the physician.

e. An entry note dated 08/06/15 at 1:00 PM by Employee G indicated the physician would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 108 follow the patient for home care services and requested the plan of care to be faxed to his office. 2. The Administrator was interviewed on 10/08/15 at 3:00 PM. The Administrator stated the Director of Nursing had an injury and needed assistance with her writing, so the Director would tell her what to write and review and initial the Administrator's entries. There was no initials following the Administrator's entry. The Administrator also stated that she was a former Registered Nurse and no longer holds a license. 3. The Director of Nursing was interviewed on 10/09/15 at 11:45 AM. The Director of Nursing stated she had an injury to her writing hand and would tell the Administrator what to write for her and then she would review and initial after the Administrators entries.	G 236		
G 250	484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure that appropriate health professionals, representing at least the scope of the program, reviewed active and closed records quarterly to determine established policies were followed in services furnished for 1 of 1 agency.	G 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 250	Continued From page 109	G 250		

Finding include:

1. The agency had a provision survey dated April 20, 21, 22, and May 4, 2015. The agency had to put a plan of correction in place by May 20, 2015. The corrections included, but not limited to:

a. Weekly monitoring of patient's plan of care visits and verification of these visits or documentation of missed visits and notification of the patient's physician.

b. Staff in-services on the need to document nutritional requirements on the plan of care.

c. The professional staff was to be in-serviced on the requirement to document with a physician's order for the specific wound care ordered and any changes in wound care per physicians order.

d. The Director of Nursing will be responsible for reviewing patient care plans and physician's orders on a weekly basis and securing physician's order for care changes as needed on each patient to prevent recurrence of this deficiency.

e. The Director of Nursing was responsible for monitoring patient care and conferencing with other professional staff to determine specific patient needs and instituting the appropriate changes in regard to the home health aide care plan.

f. The professional staff was in-services on the requirement of detailed documentation and correctness in regards to medication profile. The Director of Nursing will be responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 250	Continued From page 110 reviewing all patient admissions, resumption of care, re-evaluations and 60 day certifications to prevent recurrence of this deficiency. The agency failed to develop, implement, maintain, and evaluate a quality assessment and performance improvement program. 2. An interview with the Director of Nursing on 10/09/15 at 11:45 AM, stated that she is in the field often and does not spend a large amount of time in the office. The Director of Nursing indicated she started working for the company on June 1, 2015 and that the former Director of Nursing stepped down to be a per diem nurse in the field. 3. An interview with the Administrator on 10/09/15 at 1:50 PM, stated that the Director of Nursing did all the admissions, recertifications, and resumption of care. 4. An interview with the Administrator on 10/13/15 at 2:45 PM, stated that the Director of Nursing is responsible for the chart audits but was not able to produce any audited material. The administrator also stated the agency has not had a QAPI meeting to review audit findings since the Provisional Licensure.	G 250		
G 330	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired	G 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 330	Continued From page 111	G 330		

outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary

This CONDITION is not met as evidenced by:
Based on record review, the agency failed to ensure that the comprehensive assessment was completed in its entirety and within five days of the start of care for 1 of 1 record reviewed See G 334); failed to ensure that the Medication profile included a start date of the medication ordered, potential side effects, date of drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification for 6 out of 9 records reviewed (See G 337); failed to ensure that comprehensive recertification assessments was updated within the last 5 days during the 60 day episode for 5 of 5 records reviewed with patients who had services longer than 60 days (See G 339); failed to ensure that comprehensive assessments were completed within 48 hours of a patient's return from the hospital for 1 of 1 records reviewed of patients hospitalized (See G 340); and failed to ensure that a comprehensive assessment was completed upon discharge for 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 330	Continued From page 112 of 3 patients reviewed that was discharged from services (See G 341). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.55 Comprehensive Assessments of Patients.	G 330		
G 334	484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure that the comprehensive assessment was completed in its entirity and within five days of the start of care for 1 of 1 record reviewed. (#1) Findings include: 1. Clinical record #1, SOC (start of care) 07/20/15, included a plan of care established by the physician for the certification period of 08/03/15 to 10/03/15 for skilled nursing and home health aide services. An OASIS start of care comprehensive assessment dated 08/03/15 failed to include location and size of venouse stasis ulcers. Failed to complete vital signs, cardiopumonary assessments, complete the nutritional status, assessment of bowel elimination, abdomen assessment, neuro / emotional / behavioral status	G 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 334	Continued From page 113 assessments, failed to address the depression screening score of 6 with the physician, failed to indicate if the patient was receiving psychiatric nursing services, failed to indicate if there was any management of equipment, failed to include 24 hr supervision / clear pathways / lock w/c with transfers / infection control measures under safety measures, and failed to indicate if instructions / materials were provided. Page 18 of the assessment failed to include skilled care provided during the admission visit. The Director of Nursing failed to complete the comprehensive assessment in its entirity and within 5 days of admission. 2. The Administrator and Director of Nursing was interviewed on 10/09/15 between 1:10 PM to 1:45 PM. The Administrator stated that the Director of Nursing does all of the admissions, resumption of cares, and recertification assessessments, and does the skills check off with the home health aides. The Administrator and Director of Nursing had nothing further to add in regards to the start of care being the same day consents were signed. 3. An undated policy titled "The Admission Process" indicated, " ... The admission professional will ... Complete the Assessment Form, including OASIS data elements .... "	G 334		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 114	G 337		

noncompliance with drug therapy.

This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to ensure that the Medication profile included a start date of the medication ordered, potential side effects, date of drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification for 6 out of 9 records reviewed. (#4, 5, 6, 7, 8, and 9)

Findings include:

1. Clinical record #4, SOC 08/04/15, included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15. The correct certification period was 08/04/15 to 10/02/15. Review of the medication profile indicated the registered nurse failed to include a start date of medication ordered, potential side effects, date of drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification.

2. Clinical record #5, SOC 07/31/15, included a plan of care established by a physician with certification periods 07/31/15 to 09/10/15 and 09/10/15 to 11/05/15. The correct certification periods 07/31/15 to 09/28/15 and 09/29/15 to 11/27/15. Review of the medication profile indicated the registered nurse failed to include a start date of medication ordered, potential side effects, date of drug regimen review of the patient / caregiver, and medication reconciliation with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 115	G 337		

physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification.

3. Clinical record #6, SOC 08/04/15, included a plan of care established by a physician with certification periods of 08/04/15 to 10/25/15. The correct certification periods 08/04/15 to 10/02/15 and 10/03/15 to 12/01/15. Review of the medication profile indicated the registered nurse failed to include a dosage for the Ferrous Sulfate, failed to include route to the Ferrous Sulfate and Q Pap medications, failed to include potential side effects, a date for the drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification.

4. Clinical record #7, SOC 08/05/15, included a plan of care established by a physician with certification periods of 08/05/15 to 09/30/15. The correct certification periods 08/05/15 to 10/03/15 and 10/04/15 to 12/02/15. Review of the medication profile indicated the registered nurse failed to include the start date and route for all medications, a date for the drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care and failed to do a drug regimen review of the patient / caregiver upon recertification.

5. Clinical record #8, SOC 09/08/15, included a plan of care established by a physician for certification period of 09/08/15 to to 11/03/15. Review of the medication profile indicated the registered nurse failed to include the purpose of said medications - oxycontin, amlodipine, aspirin, levetra, omeprazole, atorvastatin, and carvedilol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 116	G 337		

as well as the listed side effects, failed to include a date for the drug regimen review of the patient / caregiver, and medication reconciliation with the physician at the start of care.

6. Clinical record #9, SOC 09/30/15, included a plan of care established by a physician for certification period of 09/30/15 to to 11/26/15.

a. Review of the medication profile indicated the registered nurse failed to include the start date, potential side effects, complete the drug regimen review of the patient / caregiver, and medication reconciliation with the physician, and signed the medication profile with date at the start of care.

b. A physician's order dated 10/05/15, indicated the patient was ordered to have neosporin ointment. The medication profile failed to be updated to include the neosporin ointment.

7. The Administrator was unable to provide additional information and / or documentation by the exit conference on 10/13/15 at 3:50 PM

8. An undated policy titled "Medication Profile" indicated, " ... Special Instructions 1. At the time of admission, the admission professional shall check all medications a client may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects ... 3. The Medication Profile shall document ... b. Date medication ordered or care initiated ... d. Medication dosage ... e. Route and frequency of administration. f. Contraindications or special precautions. g. Medication actions and side effects. h. Discontinue date ... Drug or food - drug interactions ... 10. The Medication Profile

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 117 shall be reviewed by a Registered Nurse very sixty [60] days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation and, at minimum, every sixty [60] days thereafter .... "	G 337		
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure that comprehensive recertification assessments was updated within the last 5 days during the 60 day episode for 5 of 5 records reviewed with patients who had services longer than 60 days. (#2, 4, 5, 6, 7) Findings include: 1. Clinical record #2, SOC 07/29/15, included two plans of care established by a physician for certification period 07/29/15 to 09/05/15 and 09/05/15 to 10/31/15. Review of the skilled nursing visit notes indicated a recertification assessment had been completed on 09/05/15. The correct certification period was 07/29/15 to	G 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 339	Continued From page 118	G 339		

09/26/15. The registered nurse failed to complete the recertification assessment within the last 5 days during the 60 day episode.

2. Clinical record #4, SOC 08/04/15, included a plan of care established by a physician with a start of care date of 08/06/15 and certification periods 08/06/15 to 09/25/15 and 09/26/15 to 11/07/15. The correct certification period was 08/04/15 to 10/02/15. Review of the skilled nursing visit notes, the registered nurse failed to complete the recertification assessment within the last 5 days during the 60 day episode.

3. Clinical record #5, SOC 07/31/15, included a plan of care established by a physician for certification period of 07/31/15 to to 09/10/15 and 09/10/15 to 11/05/15. The correct certification period of 07/31/15 to 09/28/15 and 09/29/15 to 11/27/15. Review of the skilled nursing visit notes, the registered nurse failed to complete the recertification assessment within the last 5 days during the 60 day episode.

4. Clinical record #6, SOC 08/04/15, included a plan of care established by a physician with certification periods of 08/04/15 to 10/25/15. The correct certification period of 08/05/15 to 10/03/15. Review of the skilled nursing visit notes, the registered nurse failed to complete the recertification assessment within the last 5 days during the 60 day episode.

5. Clinical record #7, SOC 08/05/15, included a plan of care established by a physician for certification period of 08/05/15 to to 09/30/15. The correct certification period of 08/05/15 to 10/03/15. Review of the skilled nursing visit notes, the registered nurse failed to complete the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 339	Continued From page 119 recertification assessment within the last 5 days during the 60 day episode. 6. The Director of Nursing was interviewed on 10/09/15 at 1:30 PM. The Director of Nursing stated that she had thought the certification period was 30 days. 7. An undated policy titled "Client Reassessment / Update of Comprehensive Assessment " indicated, " ... Reassessments must be done at least: 1. Every second calendar month beginning with start of care {within last five [5] days of the episode, including day sixty [60] ... Each professional discipline will be responsible for reassessing care / services at least every fifty - six [56 -60] days while the client is skilled services .... "	G 339		
G 340	484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure that comprehensive assessments were completed within 48 hours of a patient's return from the hospital for 1 of 1 records reviewed of patients hospitalized. (#4) Findings include: 1. Clinical record #4, SOC 08/04/15, included a	G 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 340	Continued From page 120 plan of care established by a physician with a start of care date of 08/06/15 and certification periods and 09/26/15 to 11/07/15. Review of the clinical revealed an order to hold services due to the patient being hospitalized from 09/18/15 to 09/25/15. The clinical record failed to include a resumption of care comprehensive assessment within 48 hours of discharge from the hospital. 2. The Director of Nursing was interviewed on 10/09/15 at 1:30 PM. The Director of Nursing stated she takes notes out in the field and does not use the OASIS forms that the agency provides. The Director of Nursing stated once she gets back to the office, she puts the information in the computer and prints it out once completed. The Director of Nursing indicated that she did not print this resumption of care assessment and that she was having problems with the computer system saving her information. The Director of Nursing was not able to provide any further information. 3. An undated policy titled "Client Reassessment / Update of Comprehensive Assessment" indicated, " ... Reassessments must be done at least ... 2. Within forty - eight [48] hours of [or knowledge of] client return home from hospital admission of more than twenty - four [24] hours of any reason other than diagnostic testing .... "	G 340		
G 341	484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. This STANDARD is not met as evidenced by:	G 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 341	Continued From page 121	G 341		

Based on record review and interview, the agency failed to ensure that a comprehensive assessment was completed upon discharge for 2 of 3 patients reviewed that was discharged from services. (# 1 and 3)

Findings include:

1. The clinical record for patient #1, SOC 07/20/15, was reviewed on 10/08/15. The clinical record included a plan of care established by a physician for a start of care date of 08/03/15 and a certification period of 08/03/15 to 10/03/15, with orders for skilled nursing one time a week for wound care.

a. The last skilled nursing visit was done on 08/19/15.

b. The last home health aide visit was done on 09/06/15.

c. The letter dated 08/24/15, indicated that the agency was discharging the patient effective 09/11/15. The agency failed to complete a discharge assessment on 09/11/15.

2. The clinical record for patient #3, SOC 11/13/14, was reviewed on 10/13/15 at 11:00 AM. The clinical record included a plan of care established by a physician for certification period of 05/14/15 to 07/13/15.

a. Review of the skilled nursing visit notes, the last skilled nursing visit note was 06/11/15.

b. Review of the physician orders, an order to discharge the patient was written on 06/29/15. The agency failed to complete a discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K131	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AGES HOME HEALTH CARE INC	1081 THIRD AVENUE, SW, SUITE # 5 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 341	Continued From page 122 assessment. 3. The Administrator was interviewed on 10/13/15 at 11:45 AM. The Administrator stated the chart was closed on 07/11/15 and that Employee G did not do a discharge visit or summary on patient #3. 4. An undated policy titled "Client Reassessment / Update of Comprehensive Assessment" indicated, " ... Reassessments must be done at least ... 3. Within forty - eight [48] hours of [or knowledge of] discharge or transfer .... "	G 341		